
HOUSE BILL 1476

State of Washington

69th Legislature

2025 Regular Session

By Representative Ormsby; by request of Office of Financial Management

Read first time 01/21/25. Referred to Committee on Appropriations.

1 AN ACT Relating to delaying the rebasing of the nursing home
2 payment rates to 2028; 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 2023 c 475 s 942 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) (a) 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. Except as provided in (b) of this
20 subsection, direct care must be paid at a fixed rate, based on one
21 hundred percent or greater of statewide case mix neutral median

1 costs, but shall be capped so that a nursing home provider's direct
2 care rate does not exceed 118 percent of its base year's direct care
3 allowable costs except if the provider is below the minimum staffing
4 standard established in RCW 74.42.360(2). Direct care must be
5 performance-adjusted for acuity every six months, using case mix
6 principles. Direct care must be regionally adjusted using countywide
7 wage index information available through the United States department
8 of labor's bureau of labor statistics. There is no minimum occupancy
9 for direct care. The direct care component rate allocations
10 calculated in accordance with this section must be adjusted to the
11 extent necessary to comply with RCW 74.46.421.

12 (b) Unless a nursing home provider is below the minimum staffing
13 standard established in RCW 74.42.360(2), a provider's direct care
14 rate relative to its base year's direct care allowable costs must be
15 capped as follows:

- 16 (i) For fiscal year 2023, the cap must not exceed 165 percent;
17 (ii) For fiscal year 2024, the cap must not exceed 153 percent;
18 and
19 (iii) For fiscal year 2025, the cap must not exceed 142 percent.

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

29 (b) A minimum occupancy assumption must be applied to indirect
30 care as follows:

- 31 (i) For fiscal year 2023, the assumption must be 75 percent;
32 (ii) For fiscal year 2024, the assumption must be 80 percent; and
33 (iii) For fiscal year 2025, the assumption must be 80 percent.

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

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

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

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

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

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

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

1 department shall use renovation data back to 1994 as submitted on
2 facility cost reports. Beginning July 1, 2016, facility ages must be
3 reduced in future years if the value of the renovation completed in
4 any year exceeds two thousand dollars times the number of licensed
5 beds. The cost of the renovation must be divided by the accumulated
6 depreciation per bed in the year of the renovation to determine the
7 equivalent number of new replacement beds. The new age for the
8 facility is a weighted average with the replacement bed equivalents
9 reflecting an age of zero and the existing licensed beds, minus the
10 new bed equivalents, reflecting their age in the year of the
11 renovation. At no time may the depreciated age be less than zero or
12 greater than forty-four years.

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

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

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

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

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

39 (c) The facility quality score must be point based, using at a
40 minimum the facility's most recent available three-quarter average

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

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

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

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

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

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

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

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

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

33 (7) Reimbursement of the safety net assessment imposed by chapter
34 74.48 RCW and paid in relation to medicaid residents must be
35 continued.

36 (8) (a) ~~((The))~~ Except as provided in (c) of this subsection, the
37 direct care and indirect care components must be rebased in even-
38 numbered years, beginning with rates paid on July 1, 2016. Rates paid
39 on July 1, 2016, must be based on the 2014 calendar year cost report.
40 On a percentage basis, after rebasing, the department must confirm

1 that the statewide average daily rate has increased at least as much
2 as the average rate of inflation, as determined by the skilled
3 nursing facility market basket index published by the centers for
4 medicare and medicaid services, or a comparable index. If after
5 rebasing, the percentage increase to the statewide average daily rate
6 is less than the average rate of inflation for the same time period,
7 the department is authorized to increase rates by the difference
8 between the percentage increase after rebasing and the average rate
9 of inflation.

10 (b) It is the intention of the legislature that direct and
11 indirect care rates paid in fiscal year 2022 will be rebased using
12 the calendar year 2019 cost reports. For fiscal year 2021, in
13 addition to the rates generated by (a) of this subsection, an
14 additional adjustment is provided as established in this subsection
15 (8)(b). Beginning May 1, 2020, and through June 30, 2021, the
16 calendar year costs must be adjusted for inflation by a twenty-four
17 month consumer price index, based on the most recently available
18 monthly index for all urban consumers, as published by the bureau of
19 labor statistics. It is also the intent of the legislature that,
20 starting in fiscal year 2022, a facility-specific rate add-on equal
21 to the inflation adjustment that facilities received solely in fiscal
22 year 2021, must be added to the rate. For fiscal year 2024, the
23 direct care and indirect care components shall be rebased to the 2021
24 calendar year cost report plus a 4.7 percent adjustment for
25 inflation. For fiscal year 2025, the direct and indirect care
26 components shall be rebased to the 2022 calendar year cost report
27 plus a five percent adjustment for inflation.

28 ~~((To determine the necessity of regular inflationary~~
29 ~~adjustments to the nursing facility rates, by December 1, 2020, the~~
30 ~~department shall provide the appropriate policy and fiscal committees~~
31 ~~of the legislature with a report that provides a review of rates paid~~
32 ~~in 2017, 2018, and 2019 in comparison to costs incurred by nursing~~
33 ~~facilities.)) The direct and indirect care rates calculations in
34 fiscal year 2027 using the calendar year 2025 cost reports shall go
35 into effect the following fiscal biennium, beginning in fiscal year
36 2028. The 2024 direct and indirect care rates and the one-time rate
37 add on in the 2025-2027 fiscal biennium shall remain in effect until
38 fiscal year 2028.~~

39 (9) The direct care component provided in subsection (3) of this
40 section is subject to the reconciliation and settlement process

1 provided in RCW 74.46.022(6). Beginning July 1, 2016, pursuant to
2 rules established by the department, funds that are received through
3 the reconciliation and settlement process provided in RCW
4 74.46.022(6) must be used for technical assistance, specialized
5 training, or an increase to the quality enhancement established in
6 subsection (6) of this section. The legislature intends to review the
7 utility of maintaining the reconciliation and settlement process
8 under a price-based payment methodology, and may discontinue the
9 reconciliation and settlement process after the 2017-2019 fiscal
10 biennium.

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

18 (11) It is the intent of the legislature that a rate add-on be
19 applied to the weighted average nursing facility payment rate
20 referenced in the omnibus operating appropriations act in an amount
21 necessary to ensure that the weighted average nursing facility
22 payment rate for fiscal year 2026 is equal to the weighted average
23 nursing facility payment rate for fiscal year 2025.

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