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SENATE BILL 6010

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State of Washington

64th Legislature

2015 Regular Session

By Senators Parlette and Keiser

Read first time 02/17/15. Referred to Committee on Health Care.

1 AN ACT Relating to promoting quality nursing home care with a  
2 quality workforce through value-focused, acuity-based purchasing  
3 utilizing the nursing home payment methodology; amending RCW  
4 74.42.360, 74.46.022, 74.46.431, 74.46.435, 74.46.437, 74.46.485,  
5 74.46.506, 74.46.515, 74.46.521, and 74.46.541; adding new sections  
6 to chapter 74.46 RCW; creating a new section; repealing RCW  
7 74.46.024, 74.46.803, and 74.46.807; making appropriations; providing  
8 an effective date; and declaring an emergency.

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

10 NEW SECTION. **Sec. 1.** The legislature finds the population of  
11 senior citizens who utilize medicaid long-term care services will  
12 more than double over the next few years and as such there is a need  
13 to maintain an array of quality services in all service settings to  
14 address this growing population. Skilled nursing facilities provide  
15 critical long-term care services for thousands of the most frail  
16 adults and senior citizens of Washington state. The legislature  
17 recognizes payments that focus on the value of purchasing direct care  
18 services according to the acuity of the client are needed in order to  
19 provide appropriate staffing levels and reduce unnecessary  
20 hospitalizations. It is the intent of the legislature to put in place  
21 policies and payments that promote high-quality care and reductions

1 in direct care staff turnover in our state's licensed nursing  
2 facilities. The intent of the legislature is to simplify the payment  
3 system through the elimination of rate add-ons, target funding to pay  
4 for quality workforce standards, correlate payments to the acuity and  
5 unique costs of the clients served, and promote a quality living  
6 environment for this increasingly medically complex population.

7 **Sec. 2.** RCW 74.42.360 and 1979 ex.s. c 211 s 36 are each amended  
8 to read as follows:

9 (1) The facility shall have staff on duty twenty-four hours daily  
10 sufficient in number and qualifications to carry out the provisions  
11 of RCW 74.42.010 through 74.42.570 and the policies,  
12 responsibilities, and programs of the facility.

13 (2) The facility shall maintain an average minimum of 3.4 hours  
14 per resident day in direct care staffing which must include the  
15 following:

16 (a) Direct care certified nursing aides must be no less than an  
17 average of 2.2 hours per resident day; and

18 (b) The facility, at a minimum, is required to maintain nurses on  
19 duty directly supervising resident care as follows:

20 (i) Large nonessential community providers must have a registered  
21 nurse on duty directly supervising resident care a minimum of twenty-  
22 four hours per day, seven days per week;

23 (ii) Essential community providers and small nonessential  
24 community providers must have a registered nurse on duty directly  
25 supervising resident care a minimum of sixteen hours per day, seven  
26 days per week, and a registered nurse or a licensed practical nurse  
27 on duty directly supervising resident care the remaining eight hours  
28 per day, seven days per week.

29 (3) The department shall establish in rule a reasonable  
30 compliance determination process, including a time period of no  
31 greater than six months for the review and determination of  
32 compliance, the duration of any penalty imposed, and the process for  
33 reviewing and determining compliance with this section.

34 (4) Barring exceptional circumstances, it is expected that  
35 facilities will comply with minimum staffing requirements on a  
36 regular basis.

37 **Sec. 3.** RCW 74.46.022 and 2010 1st sp.s. c 34 s 19 are each  
38 amended to read as follows:

1 The department shall establish, by rule, the procedures,  
2 principles, and conditions for the nursing facility medicaid payment  
3 system addressed by the following principles:

4 (1) The department must receive complete, annual reporting of all  
5 costs and the financial condition of each contractor, prepared and  
6 presented in a standardized manner. The department shall establish,  
7 by rule, due dates, requirements for cost report completion, actions  
8 required for improperly completed or late cost reports, fines for any  
9 statutory or regulatory noncompliance, retention requirements, and  
10 public disclosure requirements.

11 (2) The department shall examine all cost reports to determine  
12 whether the information is correct, complete, and reported in  
13 compliance with this chapter, department rules and instructions, and  
14 generally accepted accounting principles.

15 (3) Each contractor must establish and maintain, as a service to  
16 the resident, a bookkeeping system incorporated into the business  
17 records for all resident funds entrusted to the contractor and  
18 received by the contractor for the resident. The department shall  
19 adopt rules to ensure that resident personal funds handled by the  
20 contractor are maintained by each contractor in a manner that is, at  
21 a minimum, consistent with federal requirements.

22 (4) The department shall have the authority to audit resident  
23 trust funds and receivables, at its discretion.

24 (5) Contractors shall provide the department access to the  
25 nursing facility, all financial and statistical records, and all  
26 working papers that are in support of the cost report, receivables,  
27 and resident trust funds.

28 (6) The department shall establish a settlement process in order  
29 to reconcile medicaid resident days to billed days and medicaid  
30 payments for the preceding calendar year. With the exception of the  
31 settlement for the quality workforce component provided in section 13  
32 of this act, the settlement process shall ensure that any savings in  
33 the direct care or therapy care component rates be shifted only  
34 between direct care and therapy care component rates, and shall not  
35 be shifted into any other rate components.

36 (7) The department shall define and identify allowable and  
37 unallowable costs.

38 (8) A contractor shall bill the department for care provided to  
39 medicaid recipients, and the department shall pay a contractor for

1 service rendered under the facility contract and appropriately  
2 billed. Billing and payment procedures shall be specified by rule.

3 (9) The department shall establish the conditions for  
4 participation in the nursing facility medicaid payment system.

5 (10) The department shall establish procedures and a rate setting  
6 methodology for a change of ownership.

7 (11) The department shall establish, consistent with federal  
8 requirements for nursing facilities participating in the medicaid  
9 program, an appeals or exception procedure that allows individual  
10 nursing home providers an opportunity to receive prompt  
11 administrative review of payment rates with respect to such issues as  
12 the department deems appropriate.

13 (12) The department shall have authority to adopt, amend, and  
14 rescind such administrative rules and definitions as it deems  
15 necessary to carry out the policies and purposes of this chapter.

16 **Sec. 4.** RCW 74.46.431 and 2013 2nd sp.s. c 3 s 1 are each  
17 amended to read as follows:

18 (1) Nursing facility medicaid payment rate allocations shall be  
19 facility-specific and shall have six components: Direct care, therapy  
20 care, support services, operations, property, and financing  
21 allowance. The department shall establish and adjust each of these  
22 components, as provided in this section and elsewhere in this  
23 chapter, for each medicaid nursing facility in this state.

24 (2) Component rate allocations in therapy care and support  
25 services for all facilities shall be based upon a minimum facility  
26 occupancy of eighty-five percent of licensed beds, regardless of how  
27 many beds are set up or in use. Component rate allocations in  
28 operations, property, and financing allowance for essential community  
29 providers shall be based upon a minimum facility occupancy of  
30 (~~eighty-seven~~) eighty-five percent of licensed beds, regardless of  
31 how many beds are set up or in use. Component rate allocations in  
32 operations, property, and financing allowance for small nonessential  
33 community providers shall be based upon a minimum facility occupancy  
34 of ninety(~~two~~) percent of licensed beds, regardless of how many  
35 beds are set up or in use. Component rate allocations in operations,  
36 property, and financing allowance for large nonessential community  
37 providers shall be based upon a minimum facility occupancy of  
38 (~~ninety-five~~) ninety-two percent of licensed beds, regardless of  
39 how many beds are set up or in use. For all facilities, the component

1 rate allocation in direct care shall be based upon actual facility  
2 occupancy. The median cost limits used to set component rate  
3 allocations shall be based on the applicable minimum occupancy  
4 percentage. In determining each facility's therapy care component  
5 rate allocation under RCW 74.46.511, the department shall apply the  
6 applicable minimum facility occupancy adjustment before creating the  
7 array of facilities' adjusted therapy costs per adjusted resident  
8 day. In determining each facility's support services component rate  
9 allocation under RCW 74.46.515(3), the department shall apply the  
10 applicable minimum facility occupancy adjustment before creating the  
11 array of facilities' adjusted support services costs per adjusted  
12 resident day. In determining each facility's operations component  
13 rate allocation under RCW 74.46.521(3), the department shall apply  
14 the minimum facility occupancy adjustment before creating the array  
15 of facilities' adjusted general operations costs per adjusted  
16 resident day.

17 (3) Information and data sources used in determining medicaid  
18 payment rate allocations, including formulas, procedures, cost report  
19 periods, resident assessment instrument formats, resident assessment  
20 methodologies, and resident classification and case mix weighting  
21 methodologies, may be substituted or altered from time to time as  
22 determined by the department.

23 (4)(a) Direct care component rate allocations shall be  
24 established using adjusted cost report data covering at least six  
25 months. Effective July 1, 2009, the direct care component rate  
26 allocation shall be rebased, so that adjusted cost report data for  
27 calendar year 2007 is used for July 1, 2009, through June 30, 2015.  
28 Beginning July 1, 2015, the direct care component rate allocation  
29 shall be rebased biennially during every odd-numbered year thereafter  
30 using adjusted cost report data from two years prior to the rebase  
31 period, so adjusted cost report data for calendar year 2013 is used  
32 for July 1, 2015, through June 30, 2017, and so forth.

33 (b) Direct care component rate allocations established in  
34 accordance with this chapter shall be adjusted annually for economic  
35 trends and conditions by a factor or factors defined in the biennial  
36 appropriations act. The economic trends and conditions factor or  
37 factors defined in the biennial appropriations act shall not be  
38 compounded with the economic trends and conditions factor or factors  
39 defined in any other biennial appropriations acts before applying it  
40 to the direct care component rate allocation established in

1 accordance with this chapter. When no economic trends and conditions  
2 factor or factors for either fiscal year are defined in a biennial  
3 appropriations act, no economic trends and conditions factor or  
4 factors defined in any earlier biennial appropriations act shall be  
5 applied solely or compounded to the direct care component rate  
6 allocation established in accordance with this chapter.

7 (c)(i) Beginning January 1, 2016, in order for a nursing facility  
8 to receive full payment in the direct care component of this chapter,  
9 the department shall require medicaid contracted nursing facilities  
10 to maintain a minimum average of hours per resident day in direct  
11 care staffing as defined in RCW 74.42.360.

12 (ii) For any medicaid contracted nursing facility that does not  
13 comply with RCW 74.42.360, the department shall reduce prospective  
14 payments for the direct care component by up to ten percent but no  
15 less than five percent of what the facility would otherwise receive  
16 in its direct care rate.

17 (d) The department is authorized to establish rules and  
18 procedures to ensure timely and consistent reporting and to enforce  
19 compliance with (c) of this subsection. Rules may include an  
20 exceptions process for any facility that can demonstrate they have  
21 made a good faith effort to recruit and retain the minimum staffing  
22 levels required in (c) of this subsection or for other reasonable and  
23 exceptional circumstances.

24 (5)(a) Therapy care component rate allocations shall be  
25 established using adjusted cost report data covering at least six  
26 months. Effective July 1, 2009, the therapy care component rate  
27 allocation shall be cost rebased, so that adjusted cost report data  
28 for calendar year 2007 is used for July 1, 2009, through June 30,  
29 2015. Beginning July 1, 2015, the therapy care component rate  
30 allocation shall be rebased biennially during every odd-numbered year  
31 thereafter using adjusted cost report data from two years prior to  
32 the rebase period, so adjusted cost report data for calendar year  
33 2013 is used for July 1, 2015, through June 30, 2017, and so forth.

34 (b) Therapy care component rate allocations established in  
35 accordance with this chapter shall be adjusted annually for economic  
36 trends and conditions by a factor or factors defined in the biennial  
37 appropriations act. The economic trends and conditions factor or  
38 factors defined in the biennial appropriations act shall not be  
39 compounded with the economic trends and conditions factor or factors  
40 defined in any other biennial appropriations acts before applying it

1 to the therapy care component rate allocation established in  
2 accordance with this chapter. When no economic trends and conditions  
3 factor or factors for either fiscal year are defined in a biennial  
4 appropriations act, no economic trends and conditions factor or  
5 factors defined in any earlier biennial appropriations act shall be  
6 applied solely or compounded to the therapy care component rate  
7 allocation established in accordance with this chapter.

8 (6)(a) Support services component rate allocations shall be  
9 established using adjusted cost report data covering at least six  
10 months. Effective July 1, 2009, the support services component rate  
11 allocation shall be cost rebased, so that adjusted cost report data  
12 for calendar year 2007 is used for July 1, 2009, through June 30,  
13 2015. Beginning July 1, 2015, the support services component rate  
14 allocation shall be rebased biennially during every odd-numbered year  
15 thereafter using adjusted cost report data from two years prior to  
16 the rebase period, so adjusted cost report data for calendar year  
17 2013 is used for July 1, 2015, through June 30, 2017, and so forth.

18 (b) Support services component rate allocations established in  
19 accordance with this chapter shall be adjusted annually for economic  
20 trends and conditions by a factor or factors defined in the biennial  
21 appropriations act. The economic trends and conditions factor or  
22 factors defined in the biennial appropriations act shall not be  
23 compounded with the economic trends and conditions factor or factors  
24 defined in any other biennial appropriations acts before applying it  
25 to the support services component rate allocation established in  
26 accordance with this chapter. When no economic trends and conditions  
27 factor or factors for either fiscal year are defined in a biennial  
28 appropriations act, no economic trends and conditions factor or  
29 factors defined in any earlier biennial appropriations act shall be  
30 applied solely or compounded to the support services component rate  
31 allocation established in accordance with this chapter.

32 (7)(a) Operations component rate allocations shall be established  
33 using adjusted cost report data covering at least six months.  
34 Effective July 1, 2009, the operations component rate allocation  
35 shall be cost rebased, so that adjusted cost report data for calendar  
36 year 2007 is used for July 1, 2009, through June 30, 2015. Beginning  
37 July 1, 2015, the operations care component rate allocation shall be  
38 rebased biennially during every odd-numbered year thereafter using  
39 adjusted cost report data from two years prior to the rebase period,

1 so adjusted cost report data for calendar year 2013 is used for July  
2 1, 2015, through June 30, 2017, and so forth.

3 (b) Operations component rate allocations established in  
4 accordance with this chapter shall be adjusted annually for economic  
5 trends and conditions by a factor or factors defined in the biennial  
6 appropriations act. The economic trends and conditions factor or  
7 factors defined in the biennial appropriations act shall not be  
8 compounded with the economic trends and conditions factor or factors  
9 defined in any other biennial appropriations acts before applying it  
10 to the operations component rate allocation established in accordance  
11 with this chapter. When no economic trends and conditions factor or  
12 factors for either fiscal year are defined in a biennial  
13 appropriations act, no economic trends and conditions factor or  
14 factors defined in any earlier biennial appropriations act shall be  
15 applied solely or compounded to the operations component rate  
16 allocation established in accordance with this chapter.

17 (8) Total payment rates under the nursing facility medicaid  
18 payment system shall not exceed facility rates charged to the general  
19 public for comparable services.

20 (9) The department shall establish in rule procedures,  
21 principles, and conditions for determining component rate allocations  
22 for facilities in circumstances not directly addressed by this  
23 chapter, including but not limited to: Inflation adjustments for  
24 partial-period cost report data, newly constructed facilities,  
25 existing facilities entering the medicaid program for the first time  
26 or after a period of absence from the program, existing facilities  
27 with expanded new bed capacity, existing medicaid facilities  
28 following a change of ownership of the nursing facility business,  
29 facilities temporarily reducing the number of set-up beds during a  
30 remodel, facilities having less than six months of either resident  
31 assessment, cost report data, or both, under the current contractor  
32 prior to rate setting, and other circumstances.

33 (10) The department shall establish in rule procedures,  
34 principles, and conditions, including necessary threshold costs, for  
35 adjusting rates to reflect capital improvements or new requirements  
36 imposed by the department or the federal government. Any such rate  
37 adjustments are subject to the provisions of RCW 74.46.421.

38 (11) Effective July 1, 2010, there shall be no rate adjustment  
39 for facilities with banked beds. For purposes of calculating minimum

1 occupancy, licensed beds include any beds banked under chapter 70.38  
2 RCW.

3 ~~((12) Facilities obtaining a certificate of need or a  
4 certificate of need exemption under chapter 70.38 RCW after June 30,  
5 2001, must have a certificate of capital authorization in order for  
6 (a) the depreciation resulting from the capitalized addition to be  
7 included in calculation of the facility's property component rate  
8 allocation; and (b) the net invested funds associated with the  
9 capitalized addition to be included in calculation of the facility's  
10 financing allowance rate allocation.))~~

11 **Sec. 5.** RCW 74.46.435 and 2011 1st sp.s. c 7 s 2 are each  
12 amended to read as follows:

13 (1) The property component rate allocation for each facility  
14 shall be determined by dividing the sum of the reported allowable  
15 prior period actual depreciation, subject to department rule,  
16 adjusted for any capitalized additions or replacements approved by  
17 the department, and the retained savings from such cost center, by  
18 the greater of a facility's total resident days in the prior period  
19 or resident days as calculated on ~~((eighty-seven))~~ eighty-five  
20 percent facility occupancy for essential community providers,  
21 ninety~~((two))~~ percent occupancy for small nonessential community  
22 providers, or ~~((ninety-five))~~ ninety-two percent facility occupancy  
23 for large nonessential community providers. If a capitalized addition  
24 or retirement of an asset will result in a different licensed bed  
25 capacity during the ensuing period, the prior period total resident  
26 days used in computing the property component rate shall be adjusted  
27 to anticipated resident day level.

28 (2) A nursing facility's property component rate allocation shall  
29 be rebased annually, effective July 1st, in accordance with this  
30 section and this chapter.

31 (3) When a certificate of need for a new facility is requested,  
32 the department, in reaching its decision, shall take into  
33 consideration per-bed land and building construction costs for the  
34 facility which shall not exceed a maximum to be established by the  
35 secretary.

36 (4) The property component rate allocations calculated in  
37 accordance with this section shall be adjusted to the extent  
38 necessary to comply with RCW 74.46.421.

1       **Sec. 6.**    RCW 74.46.437 and 2011 1st sp.s. c 7 s 3 are each  
2 amended to read as follows:

3       (1) The department shall establish for each medicaid nursing  
4 facility a financing allowance component rate allocation. The  
5 financing allowance component rate shall be rebased annually,  
6 effective July 1st, in accordance with the provisions of this section  
7 and this chapter.

8       (2)(a) The financing allowance is (~~determined by~~) calculated  
9 by:

10       (i) Determining the net value of each facility's assets based on  
11 the original cost of the asset less any depreciation, amortization,  
12 or impairment costs made against the asset. Assets acquired between  
13 June 30, 2011, and June 30, 2015, must be included in this  
14 determination with the appropriate adjustments;

15       (ii) Multiplying the net (~~invested funds of each facility~~  
16 by ~~.04,~~) asset value determined in (a) of this subsection by an  
17 allowable factor of .075; and

18       (iii) Dividing by the greater of a nursing facility's total  
19 resident days from the most recent cost report period or resident  
20 days calculated on (~~eighty-seven~~) eighty-five percent facility  
21 occupancy for essential community providers, ninety(~~-two~~) percent  
22 facility occupancy for small nonessential community providers, or  
23 (~~ninety-five~~) ninety-two percent occupancy for large nonessential  
24 community providers.

25       (b) If a capitalized addition, renovation, replacement, or  
26 retirement of an asset will result in a different licensed bed  
27 capacity during the ensuing period, the prior period total resident  
28 days used in computing the financing allowance shall be adjusted to  
29 the greater of the anticipated resident day level or (~~eighty-seven~~)  
30 eighty-five percent of the new licensed bed capacity for essential  
31 community providers, ninety(~~-two~~) percent facility occupancy for  
32 small nonessential community providers, or (~~ninety-five~~) ninety-two  
33 percent occupancy for large nonessential community providers. For the  
34 period of July 1, 2015, through June 30, 2016, no facility may  
35 receive a financing allowance component payment to exceed ninety  
36 percent above the prospective financing allowance component payment  
37 rate provided to that facility for the period of January 1, 2015,  
38 through June 30, 2015.

39       (3) In computing the (~~portion of net invested funds representing~~  
40 ~~the net book value of tangible fixed assets, the same assets,~~

1 ~~depreciation bases, lives, and methods referred to in department~~  
2 ~~rule, including owned and leased assets, shall be utilized))~~  
3 allowable net value of each facility's assets, the department shall  
4 include tangible fixed assets and shall utilize the methods referred  
5 to in department rule including assets, depreciation bases, lives,  
6 and owned and leased assets, except that the capitalized cost of land  
7 upon which the facility is located and such other contiguous land  
8 which is reasonable and necessary for use in the regular course of  
9 providing resident care must also be included. Subject to provisions  
10 and limitations contained in this chapter, for land purchased by  
11 owners or lessors before July 18, 1984, capitalized cost of land is  
12 the buyer's capitalized cost. For all partial or whole rate periods  
13 after July 17, 1984, if the land is purchased after July 17, 1984,  
14 capitalized cost is that of the owner of record on July 17, 1984, or  
15 buyer's capitalized cost, whichever is lower. In the case of leased  
16 facilities where the net invested funds are unknown or the contractor  
17 is unable to provide necessary information to determine net invested  
18 funds, the secretary has the authority to determine an amount for net  
19 invested funds based on an appraisal conducted according to  
20 department rule.

21 (4) The financing allowance rate allocation calculated in  
22 accordance with this section shall be adjusted to the extent  
23 necessary to comply with RCW 74.46.421.

24 **Sec. 7.** RCW 74.46.485 and 2011 1st sp.s. c 7 s 4 are each  
25 amended to read as follows:

26 (1) The department shall:

27 (a) Employ the resource utilization group III case mix  
28 classification methodology. The department shall use the forty-four  
29 group index maximizing model for the resource utilization group III  
30 grouper version 5.10, but the department may revise or update the  
31 classification methodology to reflect advances or refinements in  
32 resident assessment or classification, subject to federal  
33 requirements. The department may adjust the case mix index for any of  
34 the lowest ten resource utilization group categories beginning with  
35 PA1 through PE2 to any case mix index that aids in achieving the  
36 purpose and intent of RCW 74.39A.007 and cost-efficient care unless  
37 an exception, consistent with section 12 of this act, has been  
38 granted by the department due to the choice of the client or the

1 client's family, or because the client's case manager failed to find  
2 an appropriate placement in a home or residential setting; and

3 (b) Implement minimum data set 3.0 under the authority of this  
4 section and RCW 74.46.431(3). The department must notify nursing home  
5 contractors twenty-eight days in advance the date of implementation  
6 of the minimum data set 3.0. In the notification, the department must  
7 identify for all semiannual rate settings following the date of  
8 minimum data set 3.0 implementation a previously established  
9 semiannual case mix adjustment established for the semiannual rate  
10 settings that will be used for semiannual case mix calculations in  
11 direct care until minimum data set 3.0 is fully implemented.

12 (2) A default case mix group shall be established for cases in  
13 which the resident dies or is discharged for any purpose prior to  
14 completion of the resident's initial assessment. The default case mix  
15 group and case mix weight for these cases shall be designated by the  
16 department.

17 (3) A default case mix group may also be established for cases in  
18 which there is an untimely assessment for the resident. The default  
19 case mix group and case mix weight for these cases shall be  
20 designated by the department.

21 **Sec. 8.** RCW 74.46.506 and 2011 1st sp.s. c 7 s 7 are each  
22 amended to read as follows:

23 (1) The direct care component rate allocation corresponds to the  
24 provision of nursing care for one resident of a nursing facility for  
25 one day, including direct care supplies. Therapy services and  
26 supplies, which correspond to the therapy care component rate, shall  
27 be excluded. The direct care component rate includes elements of case  
28 mix determined consistent with the principles of this section and  
29 other applicable provisions of this chapter.

30 (2) The department shall determine and update semiannually for  
31 each nursing facility serving medicaid residents a facility-specific  
32 per-resident day direct care component rate allocation, to be  
33 effective on the first day of each six-month period. In determining  
34 direct care component rates the department shall utilize, as  
35 specified in this section, minimum data set resident assessment data  
36 for each resident of the facility, as transmitted to, and if  
37 necessary corrected by, the department in the resident assessment  
38 instrument format approved by federal authorities for use in this  
39 state.

1 (3) The department may question the accuracy of assessment data  
2 for any resident and utilize corrected or substitute information,  
3 however derived, in determining direct care component rates. The  
4 department is authorized to impose civil fines and to take adverse  
5 rate actions against a contractor, as specified by the department in  
6 rule, in order to obtain compliance with resident assessment and data  
7 transmission requirements and to ensure accuracy.

8 (4) Cost report data used in setting direct care component rate  
9 allocations shall be for rate periods as specified in RCW  
10 74.46.431(4)(a).

11 (5) The department shall rebase each nursing facility's direct  
12 care component rate allocation as described in RCW 74.46.431, adjust  
13 its direct care component rate allocation for economic trends and  
14 conditions as described in RCW 74.46.431, and update its medicaid  
15 average case mix index as described in RCW 74.46.496 and 74.46.501,  
16 consistent with the following:

17 (a) Adjust total direct care costs reported by each nursing  
18 facility for the applicable cost report period specified in RCW  
19 74.46.431(4)(a) to reflect any department adjustments, and to  
20 eliminate reported resident therapy costs and adjustments, in order  
21 to derive the facility's total allowable direct care cost;

22 (b) Divide each facility's total allowable direct care cost by  
23 its adjusted resident days for the same report period, to derive the  
24 facility's allowable direct care cost per resident day;

25 (c) Divide each facility's adjusted allowable direct care cost  
26 per resident day by the facility average case mix index for the  
27 applicable quarters specified by RCW 74.46.501(6)(b) to derive the  
28 facility's allowable direct care cost per case mix unit;

29 (d) Divide nursing facilities into at least two and, if  
30 applicable, three peer groups: Those located in nonurban counties;  
31 those located in high labor-cost counties, if any; and those located  
32 in other urban counties;

33 (e) Array separately the allowable direct care cost per case mix  
34 unit for all facilities in nonurban counties; for all facilities in  
35 high labor-cost counties, if applicable; and for all facilities in  
36 other urban counties, and determine the median allowable direct care  
37 cost per case mix unit for each peer group;

38 (f) Determine each facility's semiannual direct care component  
39 rate as follows:

1 (i) Any facility whose allowable cost per case mix unit is  
2 greater than one hundred (~~ten~~) twelve percent of the peer group  
3 median established under (e) of this subsection shall be assigned a  
4 cost per case mix unit equal to one hundred (~~ten~~) twelve percent of  
5 the peer group median, and shall have a direct care component rate  
6 allocation equal to the facility's assigned cost per case mix unit  
7 multiplied by that facility's medicaid average case mix index from  
8 the applicable six-month period specified in RCW 74.46.501(6)(c);

9 (ii) Any facility whose allowable cost per case mix unit is less  
10 than or equal to one hundred (~~ten~~) twelve percent of the peer group  
11 median established under (e) of this subsection shall have a direct  
12 care component rate allocation equal to the facility's allowable cost  
13 per case mix unit multiplied by that facility's medicaid average case  
14 mix index from the applicable six-month period specified in RCW  
15 74.46.501(6)(c).

16 (6) The direct care component rate allocations calculated in  
17 accordance with this section shall be adjusted to the extent  
18 necessary to comply with RCW 74.46.421.

19 (7) Costs related to payments resulting from increases in direct  
20 care component rates, granted under authority of RCW 74.46.508 for a  
21 facility's exceptional care residents, shall be offset against the  
22 facility's examined, allowable direct care costs, for each report  
23 year or partial period such increases are paid. Such reductions in  
24 allowable direct care costs shall be for rate setting, settlement,  
25 and other purposes deemed appropriate by the department.

26 **Sec. 9.** RCW 74.46.515 and 2011 1st sp.s. c 7 s 8 are each  
27 amended to read as follows:

28 (1) The support services component rate allocation corresponds to  
29 the provision of food, food preparation, dietary, housekeeping, and  
30 laundry services for one resident for one day.

31 (2) The department shall determine each medicaid nursing  
32 facility's support services component rate allocation using cost  
33 report data specified by RCW 74.46.431(6).

34 (3) To determine each facility's support services component rate  
35 allocation, the department shall:

36 (a) Array facilities' adjusted support services costs per  
37 adjusted resident day, as determined by dividing each facility's  
38 total allowable support services costs by its adjusted resident days  
39 for the same report period, increased if necessary to a minimum

1 occupancy provided by RCW 74.46.431(2), for each facility from  
2 facilities' cost reports from the applicable report year, for  
3 facilities located within urban counties, and for those located  
4 within nonurban counties and determine the median adjusted cost for  
5 each peer group;

6 (b) Set each facility's support services component rate at the  
7 lower of the facility's per resident day adjusted support services  
8 costs from the applicable cost report period or the adjusted median  
9 per resident day support services cost for that facility's peer  
10 group, either urban counties or nonurban counties, plus (~~eight~~) ten  
11 percent; and

12 (c) Adjust each facility's support services component rate for  
13 economic trends and conditions as provided in RCW 74.46.431(6).

14 (4) The support services component rate allocations calculated in  
15 accordance with this section shall be adjusted to the extent  
16 necessary to comply with RCW 74.46.421.

17 **Sec. 10.** RCW 74.46.521 and 2011 1st sp.s. c 7 s 9 are each  
18 amended to read as follows:

19 (1) The operations component rate allocation corresponds to the  
20 general operation of a nursing facility for one resident for one day,  
21 including but not limited to management, administration, utilities,  
22 office supplies, accounting and bookkeeping, minor building  
23 maintenance, minor equipment repairs and replacements, and other  
24 supplies and services, exclusive of direct care, therapy care,  
25 support services, property, and financing allowance(~~(, and variable~~  
26 ~~return)~~)).

27 (2) The department shall determine each medicaid nursing  
28 facility's operations component rate allocation using cost report  
29 data specified by RCW 74.46.431(7)(a). Operations component rates for  
30 essential community providers shall be based upon a minimum occupancy  
31 of (~~eighty-seven~~) eighty-five percent of licensed beds. Operations  
32 component rates for small nonessential community providers shall be  
33 based upon a minimum occupancy of ninety(~~-two~~) percent of licensed  
34 beds. Operations component rates for large nonessential community  
35 providers shall be based upon a minimum occupancy of (~~ninety-five~~)  
36 ninety-two percent of licensed beds.

37 (3) For all calculations and adjustments in this subsection, the  
38 department shall use the greater of the facility's actual occupancy  
39 or an occupancy equal to (~~eighty-seven~~) eighty-five percent for

1 essential community providers, ninety(~~two~~) percent for small  
2 nonessential community providers, or (~~ninety-five~~) ninety-two  
3 percent for large nonessential community providers. To determine each  
4 facility's operations component rate the department shall:

5 (a) Array facilities' adjusted general operations costs per  
6 adjusted resident day, as determined by dividing each facility's  
7 total allowable operations cost by its adjusted resident days for the  
8 same report period for facilities located within urban counties and  
9 for those located within nonurban counties and determine the median  
10 adjusted cost for each peer group;

11 (b) Set each facility's operations component rate at the lower  
12 of:

13 (i) The facility's per resident day adjusted operations costs  
14 from the applicable cost report period adjusted if necessary for  
15 minimum occupancy; or

16 (ii) The adjusted median per resident day general operations cost  
17 for that facility's peer group, urban counties or nonurban counties;  
18 and

19 (c) Adjust each facility's operations component rate for economic  
20 trends and conditions as provided in RCW 74.46.431(7)(b).

21 (4) The operations component rate allocations calculated in  
22 accordance with this section shall be adjusted to the extent  
23 necessary to comply with RCW 74.46.421.

24 **Sec. 11.** RCW 74.46.541 and 2011 1st sp.s. c 7 s 10 are each  
25 amended to read as follows:

26 (1) The department shall establish a skilled nursing facility  
27 safety net assessment medicaid share pass through or rate add-on to  
28 reimburse the medicaid share of the skilled nursing facility safety  
29 net assessment as a medicaid allowable cost consistent with RCW  
30 74.48.030. This add-on shall not be considered an allowable cost for  
31 future year cost rebasing.

32 (2) As of July 1, 2011, supplemental payments to reimburse  
33 medicaid expenditures, including an amount to reimburse the medicaid  
34 share of the skilled nursing facility safety net assessment, not to  
35 exceed the annual medicare upper payment limit, must be provided for  
36 all years when the skilled nursing facility safety net assessment is  
37 levied, consistent with RCW 74.48.030. These supplemental payments,  
38 at a minimum, must be sufficient to reimburse the medicaid share of  
39 the assessment for those paying the assessment. The part of these

1 supplemental payments that reimburses the medicaid share of the  
2 assessment are not subject to the reconciliation and settlement  
3 process provided in RCW 74.46.022(6).

4 (3) Skilled nursing facility safety net assessment revenue in  
5 excess of the amount needed to reimburse the medicaid share of the  
6 skilled nursing facility safety net assessment as described in this  
7 section may only be appropriated consistent with RCW 74.48.020 for  
8 nursing facility medicaid rates.

9 NEW SECTION. Sec. 12. (1) Beginning July 1, 2015, the  
10 department shall track outcomes for clients in the resource  
11 utilization group categories beginning with PA1 through PE2 for which  
12 the nursing facilities received a reduced payment as permitted in RCW  
13 74.46.485. On or before October 10, 2015, the department shall  
14 provide a preliminary report to stakeholders, the office of financial  
15 management, and legislative fiscal committees on its effectiveness of  
16 achieving cost-efficient care through the use of these case mix  
17 adjustments. A final report is due to the legislature on or before  
18 January 6, 2016.

19 (2) The department shall develop and implement an exception  
20 process for facility rate reductions on any individual who scores  
21 within the PA1 through PE2 resource utilization group categories who  
22 remains in the current nursing facility due to client choice, the  
23 client's family choice, or because of the discretion or  
24 recommendations from the client's case manager. If the case manager  
25 fails to find another medicaid placement or denies or prohibits the  
26 facility from moving or discharging the client from a skilled nursing  
27 facility bed, then the facility shall be granted an exception from  
28 the reduction.

29 NEW SECTION. Sec. 13. (1) Beginning July 1, 2015, the  
30 department shall establish a new rate component to provide a quality  
31 workforce nursing facility payment. To determine eligibility for this  
32 payment for the period of July 1, 2015, through June 30, 2017, the  
33 department shall review the annual average hours data provided in the  
34 2013 nursing facility medicaid cost report. During the review, any  
35 facility that is found to be below the minimum requirements found in  
36 RCW 74.42.360 is eligible to receive the quality workforce payment.  
37 The amount of the payment must be determined for each qualifying  
38 facility by multiplying the average annual hours of deficiency for

1 each facility by the annual average wages reported in the 2013  
2 nursing facility medicaid cost report and dividing these results by  
3 the projected number of medicaid resident days. These calculations  
4 are one time and once calculated, the payment per resident day must  
5 remain constant for the entire period.

6 (2) For the period of July 1, 2015, through June 30, 2016, the  
7 department shall do a review of the prospective payment rate for each  
8 facility as calculated according to chapter 74.46 RCW and as modified  
9 by subsection (1) of this section and compare it to the payment rate  
10 in effect on June 30, 2015. For any facility that would realize a  
11 reduction in net revenues of medicaid payments and safety net  
12 assessment fees, the department shall review for criteria for a  
13 quality workforce payment to stabilize quality care. The quality  
14 workforce payment criteria must be determined by calculating the  
15 medicaid payment and safety net assessment fee net revenue loss for  
16 each facility and dividing it by the facility's medicaid patient days  
17 to determine the loss in a per patient day amount. Any facility that  
18 would realize a loss of more than three dollars and forty cents per  
19 patient day, shall meet the criteria for the quality workforce  
20 payment. To calculate the payment, each facility's loss in per  
21 patient day amount must be adjusted down to a factor of three dollars  
22 and forty cents and the difference between this and the initial  
23 calculated loss in per patient day amount must be added to the  
24 facility specific rate as a quality workforce payment per patient  
25 day. Allowable costs for this payment include direct care, therapy  
26 care, support services, and operations. No more than twenty percent  
27 of this payment may be used for operations. This payment is subject  
28 to settlement as identified in subsection (7) of this section.

29 (3) On July 1, 2017, funding appropriated for subsection (1) of  
30 this section must be added to the direct care rate component for each  
31 facility that qualified to receive the funding. In order to calculate  
32 the amount added to the direct care rate component for each facility,  
33 the department shall calculate the per resident day payment amount by  
34 reviewing quality workforce payments provided under subsection (1) of  
35 this section to each individual facility less any funds returned to  
36 the state by each facility through the quality workforce nursing  
37 facility payment settlement process identified in subsection (7) of  
38 this section.

39 (4) Subject to appropriation, beginning July 1, 2017, and  
40 annually thereafter, the legislature shall define the criteria for

1 the quality workforce nursing facility payment within the biennial  
2 appropriations act.

3 (5) Beginning July 1, 2016, and semiannually thereafter, any  
4 facility that is found out of compliance with the minimum staffing  
5 requirements is subject to reduced payments in direct care as  
6 identified in RCW 74.46.431 regardless of whether or not the facility  
7 accepted the quality workforce nursing facility payment add-on.

8 (6) The department shall complete a study by January 1, 2019,  
9 about the impact of new increased staffing standards on resident  
10 satisfaction, worker turnover, worker satisfaction, and resident  
11 health outcomes. The study must also report on the effectiveness of  
12 the enforcement mechanisms to ensure that staffing minimums are  
13 regularly met and that any complaints received are promptly  
14 investigated. The review must include a consideration of and  
15 recommendations on the benefits and costs of further increasing  
16 minimum staffing levels.

17 (7) The quality workforce component must be used for purposes  
18 specified in this section and is subject to the reconciliation and  
19 settlement process provided in RCW 74.46.022(6). Costs related to  
20 quality workforce payments may not be included in the calculations  
21 for the allowable cost limits as identified in RCW 74.46.506 and  
22 74.46.515. Costs related to subsection (1) of this section must be  
23 settled in relation to payments made under subsection (1) of this  
24 section. Costs related to subsection (2) of this section must be  
25 settled in relation to the allowable costs as specified in subsection  
26 (2) of this section.

27 NEW SECTION. **Sec. 14.** (1) The sum of sixty-eight million three  
28 hundred seventy-one thousand dollars is appropriated for the fiscal  
29 year ending June 30, 2016, from the skilled nursing facility safety  
30 net trust fund to the department of social and health services long-  
31 term care division for the purposes of providing payments in the  
32 components of direct care, therapy care, support services,  
33 operations, property, financing allowance, and the quality workforce  
34 payment to assist facilities in providing a stable workforce and  
35 meeting the minimum staffing requirements of this act.

36 (2) The sum of sixty-eight million three hundred seventy-one  
37 thousand dollars is appropriated for the fiscal year ending June 30,  
38 2017, from the skilled nursing facility safety net trust fund to the  
39 department of social and health services long-term care division for

1 the purposes of providing payments in the components of direct care,  
2 therapy care, support services, operations, property, financing  
3 allowance and the quality workforce payment to assist facilities in  
4 providing quality care and meeting the minimum staffing and wage  
5 requirements of this act.

6 (3) The sum of one hundred thirty-six million seven hundred  
7 forty-two thousand dollars, or as much thereof as may be necessary,  
8 is appropriated for the biennium ending June 30, 2017, from the  
9 general fund—federal to the department of social and health services  
10 long-term care division for the purposes of providing payments in the  
11 components of direct care, therapy care, support services,  
12 operations, property, financing allowance, and the quality workforce  
13 payment to assist facilities in providing quality care and meeting  
14 the minimum staffing and wage requirements of this act.

15 NEW SECTION. **Sec. 15.** The following acts or parts of acts are  
16 each repealed:

17 (1) RCW 74.46.024 (Pay-for-performance supplemental payment  
18 structure—Establishing procedures, principles, and conditions) and  
19 2010 1st sp.s. c 34 s 20;

20 (2) RCW 74.46.803 (Certificate of capital authorization—Rules—  
21 Emergency situations) and 2008 c 255 s 1 & 2001 1st sp.s. c 8 s 16;  
22 and

23 (3) RCW 74.46.807 (Capital authorization—Determination) and 2008  
24 c 255 s 2 & 2001 1st sp.s. c 8 s 15.

25 NEW SECTION. **Sec. 16.** Sections 12 and 13 of this act are each  
26 added to chapter 74.46 RCW.

27 NEW SECTION. **Sec. 17.** 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 July 1, 2015.

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