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**HOUSE BILL 1571**

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**State of Washington**

**68th Legislature**

**2023 Regular Session**

**By** Representatives Tharinger and Harris

1 AN ACT Relating to nursing facility rates; amending RCW 74.46.501  
2 and 74.46.561; creating a new section; and declaring an emergency.

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

4 **Sec. 1.** RCW 74.46.501 and 2021 c 334 s 992 are each amended to  
5 read as follows:

6 (1) From individual case mix weights for the applicable quarter,  
7 the department shall determine two average case mix indexes for each  
8 medicaid nursing facility, one for all residents in the facility,  
9 known as the facility average case mix index, and one for medicaid  
10 residents, known as the medicaid average case mix index.

11 (2)(a) In calculating a facility's two average case mix indexes  
12 for each quarter, the department shall include all residents or  
13 medicaid residents, as applicable, who were physically in the  
14 facility during the quarter in question based on the resident  
15 assessment instrument completed by the facility and the requirements  
16 and limitations for the instrument's completion and transmission  
17 (January 1st through March 31st, April 1st through June 30th, July  
18 1st through September 30th, or October 1st through December 31st).

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

1 (3) Both the facility average and the medicaid average case mix  
2 indexes shall be determined by multiplying the case mix weight of  
3 each resident, or each medicaid resident, as applicable, by the  
4 number of days, as defined in this section and as applicable, the  
5 resident was at each particular case mix classification or group, and  
6 then averaging.

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

11 (5) The cut-off date for the department to use resident  
12 assessment data, for the purposes of calculating both the facility  
13 average and the medicaid average case mix indexes, and for  
14 establishing and updating a facility's direct care component rate,  
15 shall be one month and one day after the end of the quarter for which  
16 the resident assessment data applies.

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

35 (b) Except during the 2021-2023 fiscal biennium, the facility  
36 average case mix index used to establish each nursing facility's  
37 direct care component rate shall be based on an average of calendar  
38 quarters of the facility's average case mix indexes from the four  
39 calendar quarters occurring during the cost report period used to

1 rebase the direct care component rate allocations as specified in RCW  
2 74.46.561.

3 (c) Except during the 2021-2023 fiscal biennium, the medicaid  
4 average case mix index used to update or recalibrate a nursing  
5 facility's direct care component rate semiannually shall be from the  
6 calendar six-month period commencing nine months prior to the  
7 effective date of the semiannual rate. For example, July 1, 2010,  
8 through December 31, 2010, direct care component rates shall utilize  
9 case mix averages from the October 1, 2009, through March 31, 2010,  
10 calendar quarters, and so forth.

11 (d) The department shall establish a methodology to use the case  
12 mix to set the direct care component (~~(rate)~~) rate in the 2021-2023  
13 fiscal biennium.

14 (e) The department may adjust the calculation of case mix as  
15 necessary in the event the federal department of health and human  
16 services discontinues or changes the provision of the minimum data  
17 set 3.0 for the purposes of calculating resource utilization groups  
18 as referenced in this subsection.

19 **Sec. 2.** RCW 74.46.561 and 2022 c 297 s 966 are each amended to  
20 read as follows:

21 (1) The legislature adopts a new system for establishing nursing  
22 home payment rates beginning July 1, 2016. Any payments to nursing  
23 homes for services provided after June 30, 2016, must be based on the  
24 new system. The new system must be designed in such a manner as to  
25 decrease administrative complexity associated with the payment  
26 methodology, reward nursing homes providing care for high acuity  
27 residents, incentivize quality care for residents of nursing homes,  
28 and establish minimum staffing standards for direct care.

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

32 (3) The direct care component must include the direct care and  
33 therapy care components of the previous system, along with food,  
34 laundry, and dietary services. Direct care must be paid at a fixed  
35 rate, based on (~~one hundred~~) 111 percent or greater of statewide  
36 case mix neutral median costs, but for fiscal year 2023 shall be  
37 capped so that a nursing home provider's direct care rate does not  
38 exceed 165 percent of its base year's direct care allowable costs  
39 except if the provider is below the minimum staffing standard

1 established in RCW 74.42.360(2). The legislature intends to remove  
2 the cap on direct care rates by June 30, 2027. Direct care must be  
3 performance-adjusted for acuity every six months, using case mix  
4 principles. Direct care must be regionally adjusted using countywide  
5 wage index information available through the United States department  
6 of labor's bureau of labor statistics. There is no minimum occupancy  
7 for direct care. The direct care component rate allocations  
8 calculated in accordance with this section must be adjusted to the  
9 extent necessary to comply with RCW 74.46.421.

10 (4) The indirect care component must include the elements of  
11 administrative expenses, maintenance costs, and housekeeping services  
12 from the previous system. A minimum occupancy assumption (~~of ninety~~  
13 ~~percent~~) equal to 105 percent of the statewide average occupancy of  
14 the calendar year prior to the beginning of the fiscal year must be  
15 applied to indirect care, except during fiscal year 2023 when the  
16 minimum occupancy assumption must be 75 percent. Only facilities used  
17 to calculate the median will be used to calculate the statewide  
18 average occupancy. Indirect care must be paid at a fixed rate, based  
19 on (~~ninety~~) 92 percent or greater of statewide median costs. The  
20 indirect care component rate allocations calculated in accordance  
21 with this section must be adjusted to the extent necessary to comply  
22 with RCW 74.46.421.

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

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

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

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

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

25 (e) The average age is the actual facility age reduced for  
26 significant renovations. Significant renovations are defined as those  
27 renovations that exceed two thousand dollars per bed in a calendar  
28 year as reported on the annual cost report submitted in accordance  
29 with this chapter. For the rate beginning July 1, 2016, the  
30 department shall use renovation data back to 1994 as submitted on  
31 facility cost reports. Beginning July 1, 2016, facility ages must be  
32 reduced in future years if the value of the renovation completed in  
33 any year exceeds two thousand dollars times the number of licensed  
34 beds. The cost of the renovation must be divided by the accumulated  
35 depreciation per bed in the year of the renovation to determine the  
36 equivalent number of new replacement beds. The new age for the  
37 facility is a weighted average with the replacement bed equivalents  
38 reflecting an age of zero and the existing licensed beds, minus the  
39 new bed equivalents, reflecting their age in the year of the

1 renovation. At no time may the depreciated age be less than zero or  
2 greater than forty-four years.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 (8)(a) The direct care and indirect care components must be  
25 rebased (~~(in even-numbered years)~~) annually, beginning with rates  
26 paid on July 1, (~~(2016)~~) 2023. (~~(Rates paid on July 1, 2016, must be~~  
27 ~~based on the 2014 calendar year cost report.)~~) On a percentage basis,  
28 after rebasing, the department must confirm that the statewide  
29 average daily rate has increased at least as much as the average rate  
30 of inflation, as determined by the skilled nursing facility market  
31 basket index published by the centers for medicare and medicaid  
32 services, or a comparable index. If after rebasing, the percentage  
33 increase to the statewide average daily rate is less than the average  
34 rate of inflation for the same time period, the department is  
35 authorized to increase rates by the difference between the percentage  
36 increase after rebasing and the average rate of inflation.

37 (b) (~~(It is the intention of the legislature that direct and~~  
38 ~~indirect care rates paid in fiscal year 2022 will be rebased using~~  
39 ~~the calendar year 2019 cost reports. For fiscal year 2021)~~) Beginning  
40 July 1, 2023, in addition to the rates generated by (a) of this



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

11 ~~(c) To determine the necessity of regular inflationary~~  
12 ~~adjustments to the nursing facility rates, by December 1, 2020, the~~  
13 ~~department shall provide the appropriate policy and fiscal committees~~  
14 ~~of the legislature with a report that provides a review of rates paid~~  
15 ~~in 2017, 2018, and 2019 in comparison to costs incurred by nursing~~  
16 ~~facilities)) the skilled nursing facility four quarter moving average~~  
17 ~~percent change for the most recent quarter from the annual market~~  
18 ~~basket index as published by the centers for medicare and medicaid~~  
19 ~~services and utilized for the prospective payment systems in the~~  
20 ~~federal register.~~

21 (9) The direct care component provided in subsection (3) of this  
22 section is subject to the reconciliation and settlement process  
23 provided in RCW 74.46.022(6). Beginning July 1, 2016, pursuant to  
24 rules established by the department, funds that are received through  
25 the reconciliation and settlement process provided in RCW  
26 74.46.022(6) must be used for technical assistance, specialized  
27 training, or an increase to the quality enhancement established in  
28 subsection (6) of this section. The legislature intends to review the  
29 utility of maintaining the reconciliation and settlement process  
30 under a price-based payment methodology, and may discontinue the  
31 reconciliation and settlement process after the 2017-2019 fiscal  
32 biennium.

33 (10) (~~Compared to the rate in effect June 30, 2016, including~~  
34 ~~all cost components and rate add-ons, no facility may receive a rate~~  
35 ~~reduction of more than one percent on July 1, 2016, more than two~~  
36 ~~percent on July 1, 2017, or more than five percent on July 1, 2018.~~  
37 ~~To ensure that the appropriation for nursing homes remains cost~~  
38 ~~neutral, the department is authorized to cap the rate increase for~~  
39 ~~facilities in fiscal years 2017, 2018, and 2019.)) (a) On an~~  
40 ~~individual facility basis, the department shall annually review the~~

1 direct care rate on June 30th compared to the direct care rate on  
2 July 1st to determine the annual direct care rate increase over the  
3 previous fiscal year. Beginning July 1, 2023, 29 percent of a  
4 facility's annual direct care rate increase over the previous fiscal  
5 year's direct care rate shall be allocated solely to address low-wage  
6 equity for low-wage direct care workers.

7 (b) For the purpose of this subsection, "low-wage direct care  
8 workers" means certified nursing assistants, dietary workers, laundry  
9 workers, medical assistants, nursing assistants registered, cooks,  
10 feeding assistants, activity assistants, medical technicians, bath  
11 aides, medical records assistants, rehabilitation and restorative  
12 aides, social workers and those who work in social services, and  
13 other workers who provide direct care to residents and who do not  
14 have a managerial role. This allocation shall not be used to fund  
15 agency staffing. This allocation shall not be used to fund overtime  
16 costs above the regular rate of pay.

17 (11)(a) On an individual facility basis, the department shall  
18 annually review the indirect care rate on June 30th compared to the  
19 indirect care rate on July 1st to determine the annual indirect care  
20 rate increase over the previous fiscal year. Beginning July 1, 2023,  
21 10 percent of a facility's annual indirect care rate increase over  
22 the previous fiscal year's indirect rate shall be allocated solely to  
23 address low-wage equity for low-wage indirect care workers.

24 (b) For the purpose of this subsection, "low-wage indirect care  
25 workers" means central supply workers; housekeeping workers;  
26 subcontracted housekeeping workers; reception workers; staffing  
27 coordinators; building maintenance workers; transportation,  
28 facilities, and maintenance workers; and other workers not providing  
29 direct care to residents and who do not have a managerial role.

30 (12)(a) Annually, each facility shall report to the department  
31 the average wage and the hourly wage range for low-wage direct care  
32 workers and low-wage indirect care workers referenced in subsections  
33 (10) and (11) of this section. The department shall provide a  
34 verification and recovery process on funds allocated to low-wage  
35 direct care and low-wage indirect care worker wages by performing a  
36 comparative analysis from one year to the next and validating that  
37 each provider has increased average wages for one or more designated  
38 low-wage worker categories included in subsections (10)(b) and  
39 (11)(b) of this section by no less than the facility-specific amounts  
40 the provider received solely for low-wage equity. The verification

1 and recovery process in this subsection is a distinct and separate  
2 process from the settlement process described in RCW 74.46.022.

3 (b) Funds recovered through this verification and recovery  
4 process shall be reinvested into the quality incentive component in  
5 subsection (6) of this section as determined by the department in  
6 collaboration with appropriate stakeholders.

7 (c) In its use of data collected on facility-specific wages of  
8 low-wage workers, the department must conform to the safe harbor  
9 guidelines outlined by the United States department of justice and  
10 the federal trade commission. Data must be aggregated so that no  
11 single facility can be identified, each statistic reported must have  
12 at least five companies reporting data, and no single company should  
13 represent more than 25 percent of any statistic reported. The  
14 individual facility wage data reported to the department for the  
15 purposes of this subsection and subsections (10) and (11) of this  
16 section is not subject to disclosure under the public records act in  
17 chapter 42.56 RCW. The consolidated findings from the verification  
18 and recovery process are subject to disclosure under the public  
19 records act in chapter 42.56 RCW.

20 NEW SECTION. Sec. 3. (1) The department of social and health  
21 services shall convene a stakeholder work group comprised of the two  
22 statewide nursing home associations and the labor organization that  
23 represents long-term care workers to study the impacts of the low-  
24 wage funding provided under RCW 74.46.561. Specifically, the study  
25 shall include a review of whether the low-wage funding has, overall,  
26 improved the ability of facilities to retain staff in the affected  
27 categories and whether the low-wage funding has enabled the  
28 facilities to attract and hire additional low-wage staff.

29 (2) As part of this study, the stakeholder work group shall  
30 review and determine if a portion of the low-wage worker funding, or  
31 additional and separate enhanced funding, should be allocated  
32 specifically for low-wage worker benefits such as child care,  
33 transportation, medical insurance, or retirement benefits.

34 (3) By December 1, 2025, the department shall submit a report to  
35 the appropriate committees of the legislature that contains the  
36 results of the study and includes recommendations for expanding the  
37 use of low-wage worker funding, or applying new funds, to support the  
38 provision of benefits to these affected workers.

1        NEW SECTION.    **Sec. 4.**    This act is necessary for the immediate  
2    preservation of the public peace, health, or safety, or support of  
3    the state government and its existing public institutions, and takes  
4    effect immediately.

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