H-1784.1

HOUSE BILL 2137

State of Washington 64th Legislature 2015 Regular Session

By Representatives Cody and Harris

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Component rate allocations in therapy care and support services for all facilities shall be based upon a minimum facility occupancy of eighty-five percent of licensed beds, regardless of how many beds are set up or in use. Component rate allocations in operations, property, and financing allowance for essential community providers shall be based upon a minimum facility occupancy of ((~~eighty-seven~~)) eighty-five percent of licensed beds, regardless of how many beds are set up or in use. Component rate allocations in operations, property, and financing allowance for small nonessential community providers shall be based upon a minimum facility occupancy of ninety((~~-two~~)) percent of licensed beds, regardless of how many beds are set up or in use. Component rate allocations in operations, property, and financing allowance for large nonessential community providers shall be based upon a minimum facility occupancy of ((~~ninety-five~~)) ninety-two percent of licensed beds, regardless of how many beds are set up or in use. For all facilities, the component

rate allocation in direct care shall be based upon actual facility occupancy. The median cost limits used to set component rate allocations shall be based on the applicable minimum occupancy percentage. In determining each facility's therapy care component rate allocation under RCW 74.46.511, the department shall apply the applicable minimum facility occupancy adjustment before creating the array of facilities' adjusted therapy costs per adjusted resident day. In determining each facility's support services component rate allocation under RCW 74.46.515(3), the department shall apply the applicable minimum facility occupancy adjustment before creating the array of facilities' adjusted support services costs per adjusted resident day. In determining each facility's operations component rate allocation under RCW 74.46.521(3), the department shall apply the minimum facility occupancy adjustment before creating the array of facilities' adjusted general operations costs per adjusted resident day.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Operations component rate allocations established in accordance with this chapter shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. The economic trends and conditions factor or factors defined in the biennial appropriations act shall not be compounded with the economic trends and conditions factor or factors defined in any other biennial appropriations acts before applying it to the operations component rate allocation established in accordance with this chapter. When no economic trends and conditions factor or factors for either fiscal year are defined in a biennial appropriations act, no economic trends and conditions factor or factors defined in any earlier biennial appropriations act shall be applied solely or compounded to the operations component rate allocation established in accordance with this chapter.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) The department shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NEW SECTION. **Sec. 17.** This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect July 1, 2015.

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