S-0356.2

SENATE BILL 5838

State of Washington 63rd Legislature 2013 Regular Session

By Senators Hewitt, Keiser, and Becker

AN ACT Relating to restoring some of the nursing facility payment methodology changes made during 2011; amending RCW 74.46.431, 74.46.435, 74.46.437, 74.46.485, 74.46.501, 74.46.506, 74.46.515, and 74.46.521; adding a new section to chapter 74.46 RCW; providing an effective date; and declaring an emergency.

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

Sec. 1. RCW 74.46.431 and 2011 1st sp.s. c 7 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, 2013. Beginning July 1, 2013, 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 2011 is used for July 1, 2013, through June 30, 2015, 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.

(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, 2013. Beginning July 1, 2013, 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 2011 is used for July 1, 2013, through June 30, 2015, 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, 2013. Beginning July 1, 2013, 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 2011 is used for July 1, 2013, through June 30, 2015, 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, 2013. Beginning July 1, 2013, 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 2011 is used for July 1, 2013, through June 30, 2015, 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. 2. 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. 3. 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) The financing allowance is determined by multiplying the net invested funds of each facility by ((~~.04~~)) .085, and 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. 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.

(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, 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. 4. 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~~)); 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. 5. RCW 74.46.501 and 2011 1st sp.s. c 7 s 6 are each amended to read as follows:

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

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

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

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

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

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

(6)(a) Although the facility average and the medicaid average case mix indexes shall both be calculated quarterly, the cost-rebasing period facility average case mix index will be used throughout the applicable cost-rebasing period in combination with cost report data as specified by RCW 74.46.431 and 74.46.506, to establish a facility's allowable cost per case mix unit. To allow for the transition to

minimum data set 3.0 and implementation of resource utilization group IV for July 1, 2011, through June 30, 2013, the department shall calculate rates using the medicaid average case mix scores effective for January 1, 2011, rates ((~~adjusted under RCW 74.46.485(1)(a),~~)) and the scores shall be increased each six months during the transition period by one-half of one percent. The July 1, 2013, direct care cost per case mix unit shall be calculated by utilizing 2011 direct care costs, patient days, and 2011 facility average case mix indexes based on the minimum data set 3.0 resource utilization group IV grouper 57. A facility's medicaid average case mix index shall be used to update a nursing facility's direct care component rate semiannually.

(b) The facility average case mix index used to establish each nursing facility's direct care component rate shall be based on an average of calendar quarters of the facility's average case mix indexes from the four calendar quarters occurring during the cost report period used to rebase the direct care component rate allocations as specified in RCW 74.46.431.

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

Sec. 6. 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. 7. 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. 8. 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.

NEW SECTION. **Sec. 9.** A new section is added to chapter 74.46 RCW to read as follows:

(1)(a) The department shall establish for each medicaid nursing facility a medicaid disproportionate share component rate allocation. In determining the disproportionate share component:

(i) The disproportionate share percentage shall be assigned annually, commencing with July 1, 2013;

(ii) A disproportionate share percentage factor shall be assigned each facility based upon the percentage of medicaid recipients served at the facility as reported in the immediately preceding year's medicaid cost report, in accordance with the following:

(A) 75.01 percent to 100 percent assigns a 2.5 percent factor;

(B) 50.01 percent to 75.0 percent assigns a 1.5 percent factor;

(C) 25.01 percent to 50.0 percent assigns a 0.5 percent factor;

(D) Less than 25.0 percent assigns a 0.0 percent factor.

(b) The department shall compute the medicaid disproportionate share component rate allocation by multiplying a facility's assigned percentage factor from (a)(ii) of this subsection by the total medicaid payment rate less any safety net assessment component rate allocation determined in accordance with this chapter and rules adopted by the department.

(c) The medicaid disproportionate share component rate allocation is not subject to the reconciliation and settlement process provided for in RCW 74.46.022(6).

(2) The medicaid disproportionate share component rate allocation calculated in accordance with this section shall be adjusted to the extent necessary to comply with RCW 74.46.421.

NEW SECTION. **Sec. 10.** 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, 2013.

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