H-0270.4

HOUSE BILL 1483

State of Washington 56th Legislature 1999 Regular Session

By Representatives Cody, Parlette, Edwards and Conway

Read first time 01/26/1999. Referred to Committee on Health Care.

1 AN ACT Relating to changes to the nursing facility payment system
2 and payment for therapy services for nursing facility medicaid
3 residents; amending RCW 74.46.410, 74.46.421, 74.46.431, 74.46.506,
4 74.46.515, and 74.46.521; adding a new section to chapter 74.09 RCW;
5 adding a new section to chapter 74.46 RCW; and repealing RCW 74.46.511.

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

7 **Sec. 1.** RCW 74.46.410 and 1998 c 322 s 17 are each amended to read
8 as follows:
9 (1) Costs will be unallowable if they are not documented,
10 necessary, ordinary, and related to the provision of care services to
11 authorized patients.
12 (2) Unallowable costs include, but are not limited to, the
13 following:
14 (a) Costs of items or services not covered by the medical care
15 program. Costs of such items or services will be unallowable even if
16 they are indirectly reimbursed by the department as the result of an
17 authorized reduction in patient contribution;
18 (b) Costs of services and items provided to recipients which are
19 covered by the department's medical care program but not included in

1 the medicaid per-resident day payment rate established by the
2 department under this chapter;
3 (c) Costs associated with a capital expenditure subject to section
4 1122 approval (part 100, Title 42 C.F.R.) if the department found it
5 was not consistent with applicable standards, criteria, or plans. If
6 the department was not given timely notice of a proposed capital
7 expenditure, all associated costs will be unallowable up to the date
8 they are determined to be reimbursable under applicable federal
9 regulations;
10 (d) Costs associated with a construction or acquisition project
11 requiring certificate of need approval, or exemption from the
12 requirements for certificate of need for the replacement of existing
13 nursing home beds, pursuant to chapter 70.38 RCW if such approval or
14 exemption was not obtained;
15 (e) Interest costs other than those provided by RCW 74.46.290 on
16 and after January 1, 1985;
17 (f) Salaries or other compensation of owners, officers, directors,
18 stockholders, partners, principals, participants, and others associated
19 with the contractor or its home office, including all board of
20 directors' fees for any purpose, except reasonable compensation paid
21 for service related to patient care;
22 (g) Costs in excess of limits or in violation of principles set
23 forth in this chapter;
24 (h) Costs resulting from transactions or the application of
25 accounting methods which circumvent the principles of the payment
26 system set forth in this chapter;
27 (i) Costs applicable to services, facilities, and supplies
28 furnished by a related organization in excess of the lower of the cost
29 to the related organization or the price of comparable services,
30 facilities, or supplies purchased elsewhere;
31 (j) Bad debts of non-Title XIX recipients. Bad debts of Title XIX
32 recipients are allowable if the debt is related to covered services, it
33 arises from the recipient's required contribution toward the cost of
34 care, the provider can establish that reasonable collection efforts
35 were made, the debt was actually uncollectible when claimed as
36 worthless, and sound business judgment established that there was no
37 likelihood of recovery at any time in the future;
38 (k) Charity and courtesy allowances;

1 (l) Cash, assessments, or other contributions, excluding dues, to
2 charitable organizations, professional organizations, trade
3 associations, or political parties, and costs incurred to improve
4 community or public relations;
5 (m) Vending machine expenses;
6 (n) Expenses for barber or beautician services not included in
7 routine care;
8 (o) Funeral and burial expenses;
9 (p) Costs of gift shop operations and inventory;
10 (q) Personal items such as cosmetics, smoking materials, newspapers
11 and magazines, and clothing, except those used in patient activity
12 programs;
13 (r) Fund-raising expenses, except those directly related to the
14 patient activity program;
15 (s) Penalties and fines;
16 (t) Expenses related to telephones, televisions, radios, and
17 similar appliances in patients' private accommodations;
18 (u) Federal, state, and other income taxes;
19 (v) Costs of special care services except where authorized by the
20 department;
21 (w) Expenses of an employee benefit not in fact made available to
22 all employees on an equal or fair basis, for example, key-man insurance
23 and other insurance or retirement plans;
24 (x) Expenses of profit-sharing plans;
25 (y) Expenses related to the purchase and/or use of private or
26 commercial airplanes which are in excess of what a prudent contractor
27 would expend for the ordinary and economic provision of such a
28 transportation need related to patient care;
29 (z) Personal expenses and allowances of owners or relatives;
30 (aa) All expenses of maintaining professional licenses or
31 membership in professional organizations;
32 (bb) Costs related to agreements not to compete;
33 (cc) Amortization of goodwill, lease acquisition, or any other
34 intangible asset, whether related to resident care or not, and whether
35 recognized under generally accepted accounting principles or not;
36 (dd) Expenses related to vehicles which are in excess of what a
37 prudent contractor would expend for the ordinary and economic provision
38 of transportation needs related to patient care;

(ee) Legal and consultant fees in connection with a fair hearing against the department where a decision is rendered in favor of the department or where otherwise the determination of the department stands;

(ff) Legal and consultant fees of a contractor or contractors in connection with a lawsuit against the department;

(gg) Lease acquisition costs, goodwill, the cost of bed rights, or any other intangible assets;

(hh) All rental or lease costs other than those provided in RCW 74.46.300 on and after January 1, 1985;

(ii) Postsurvey charges incurred by the facility as a result of subsequent inspections under RCW 18.51.050 which occur beyond the first postsurvey visit during the certification survey calendar year;

(jj) Compensation paid for any purchased nursing care services, including registered nurse, licensed practical nurse, and nurse assistant services, obtained through service contract arrangement in excess of the amount of compensation paid for such hours of nursing care service had they been paid at the average hourly wage, including related taxes and benefits, for in-house nursing care staff of like classification at the same nursing facility, as reported in the most recent cost report period;

(kk) For all partial or whole rate periods after July 17, 1984, costs of land and depreciable assets that cannot be reimbursed under the Deficit Reduction Act of 1984 and implementing state statutory and regulatory provisions;

(ll) Costs reported by the contractor for a prior period to the extent such costs, due to statutory exemption, will not be incurred by the contractor in the period to be covered by the rate;

(mm) Costs of outside activities, for example, costs allocated to the use of a vehicle for personal purposes or related to the part of a facility leased out for office space;

(nn) Travel expenses outside the states of Idaho, Oregon, and Washington and the province of British Columbia. However, travel to or from the home or central office of a chain organization operating a nursing facility is allowed whether inside or outside these areas if the travel is necessary, ordinary, and related to resident care;

(oo) Moving expenses of employees in the absence of demonstrated, good-faith effort to recruit within the states of Idaho, Oregon, and Washington, and the province of British Columbia;

(pp) Depreciation in excess of four thousand dollars per year for each passenger car or other vehicle primarily used by the administrator, facility staff, or central office staff;

(qq) Costs for temporary health care personnel from a nursing pool not registered with the secretary of the department of health;

(rr) Payroll taxes associated with compensation in excess of allowable compensation of owners, relatives, and administrative personnel;

(ss) Costs and fees associated with filing a petition for bankruptcy;

(tt) All advertising or promotional costs, except reasonable costs of help wanted advertising;

(uu) Outside consultation expenses required to meet department-required minimum data set completion proficiency;

(vv) Interest charges assessed by any department or agency of this state for failure to make a timely refund of overpayments and interest expenses incurred for loans obtained to make the refunds; and

(ww) ((~~All home office or central office costs, whether on or off the nursing facility premises, and whether allocated or not to specific services, in excess of the median of those adjusted costs for all facilities reporting such costs for the most recent report period; and~~

~~(xx)~~)) Tax expenses that a nursing facility has never incurred.

Sec. 2. RCW 74.46.421 and 1998 c 322 s 18 are each amended to read as follows:

(1) The purpose of part E of this chapter is to determine nursing facility medicaid payment rates that, in the aggregate for all participating nursing facilities, are in accordance with the biennial appropriations act.

(2)(a) The department shall use the nursing facility medicaid payment rate methodologies described in this chapter to determine initial component rate allocations for each medicaid nursing facility.

(b) The initial component rate allocations shall be subject to adjustment as provided in this section in order to assure that the state-wide average payment rate to nursing facilities is less than or equal to the state-wide average payment rate specified in the biennial appropriations act.

(3) Nothing in this chapter shall be construed as creating a legal right or entitlement to any payment that (a) has not been adjusted

under this section or (b) would cause the state-wide average payment rate to exceed the state-wide average payment rate specified in the biennial appropriations act.

(4)(a) The state-wide average payment rate for any state fiscal year under the nursing facility medicaid payment system, weighted by patient days, shall not exceed the annual state-wide weighted average nursing facility payment rate identified for that fiscal year in the biennial appropriations act.

(b) If the department determines that the weighted average nursing facility payment rate calculated in accordance with this chapter is likely to exceed the weighted average nursing facility payment rate identified in the biennial appropriations act, then the department shall adjust all nursing facility payment rates proportional to the amount by which the weighted average rate allocations would otherwise exceed the budgeted rate amount. Any such adjustments shall only be made prospectively, not retrospectively, and shall be applied proportionately to each component rate allocation for each facility.

(c) Any rate adjustments made under (b) of this subsection that are in excess of the amount necessary to comply with (a) of this subsection shall be refunded to each nursing facility.

Sec. 3. RCW 74.46.431 and 1998 c 322 s 19 are each amended to read as follows:

(1) Effective October 1, 1998, nursing facility medicaid payment rate allocations shall be facility-specific and shall have six components: Direct care, ((~~therapy care,~~)) support services, tax, operations, property, and return on investment. 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)(a) All component rate allocations, excluding the tax component, 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.

(b) If a contractor elects to bank licensed beds or convert banked beds to active service under chapter 70.38 RCW, the department shall use a resident occupancy level of eighty-five percent subsequent to the decrease or increase in licensed bed capacity to adjust each affected rate component.

(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) Beginning October 1, 1998, direct care component rate allocations shall be established using adjusted cost report data covering at least six months, using a three-year rebase cycle. That is, adjusted cost report data from 1996 will be used for October 1, 1998, through June 30, 2001, direct care component rate allocations; adjusted cost report data from 1999 will be used for July 1, 2001, through June 30, 2004, direct care component rate allocations, adjusted cost report data from 2002 will be used for July 1, 2004, through July 1, 2007, direct care component rate allocations, and so forth.

(b) Beginning July 1, 1999, and for all subsequent July 1st nonrebased direct care component rate allocations, based on ((~~1996~~)) the rebase year cost report data, direct care component rate allocations shall be adjusted ((~~annually~~)) for economic trends and conditions by ((~~a factor or factors defined in the biennial appropriations act~~)) the change in the nursing home input price index without capital costs published by the health care financing administration of the department of health and human services (HCFA index). The period to be used to measure the HCFA index increase or decrease shall be the calendar year immediately preceding the July 1st nonrebased rate period. A different economic trends and conditions adjustment factor or factors may be defined in the biennial appropriations act for facilities whose direct care component rate is set equal to their adjusted June 30, 1998, rate, as provided in RCW 74.46.506(5)(k).

(c) Beginning July 1, 2001, and for all subsequent July 1st rebased direct care component rate allocations based on ((~~1999~~)) the rebase year cost report data shall be adjusted ((~~annually~~)) for economic trends and conditions by ((~~a factor or factors defined in the biennial appropriations act~~)) the change in the HCFA index for the calendar year that immediately precedes the July 1st rebased rate period, multiplied by a factor of 2.0. A different economic trends and conditions adjustment factor or factors may be defined in the biennial appropriations act for facilities whose direct care component rate is

set equal to their adjusted June 30, 1998, rate, as provided in RCW 74.46.506(5)(k).

(5)(a) ((~~Therapy care component rate allocations shall be established using adjusted cost report data covering at least six months. Adjusted cost report data from 1996 will be used for October 1, 1998, through June 30, 2001, therapy care component rate allocations; adjusted cost report data from 1999 will be used for July 1, 2001, through June 30, 2004, therapy care component rate allocations.~~

~~(b) Therapy care component rate allocations shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act.~~

~~(6)(a)~~)) Beginning October 1, 1998, support services component rate allocations shall be established using adjusted cost report data covering at least six months, using a three-year rebase cycle. That is, adjusted cost report data from 1996 shall be used for October 1, 1998, through June 30, 2001, support services component rate allocations; adjusted cost report data from 1999 shall be used for July 1, 2001, through June 30, 2004, support services component rate allocations, adjusted cost report data from 2002 will be used for July 1, 2004, through July 1, 2007, support services component rate allocations, and so forth.

(b) Beginning July 1, 1999, and for all subsequent July 1st nonrebased support services component rate allocations shall be adjusted ((~~annually~~)) for economic trends and conditions by a ((~~factor or factors defined in the biennial appropriations act~~)) change in the nursing home price input without capital costs published by the health care financing administration of the department of health and human services (HCFA index). The period to be used to measure the HCFA index increase or decrease shall be the calendar year immediately preceding the July 1st nonrebased rate period.

(c) Beginning July 1, 2001, and for all subsequent July 1st rebased support services component rate allocations, the rebase period cost report data shall be adjusted for economic trends and conditions by the change in the HCFA index for the calendar year that immediately precedes the July 1st rebased rate period, multiplied by a factor of 2.0.

((~~(7)~~)) (6)(a) Beginning October 1, 1998, operations component rate allocations shall be established using adjusted cost report data

covering at least six months, using a three-year rebase cycle. That is, adjusted cost report data from 1996 shall be used for October 1, 1998, through June 30, 2001, operations component rate allocations; adjusted cost report data from 1999 shall be used for July 1, 2001, through June 30, 2004, operations component rate allocations, adjusted cost report data from 2002 will be used for July 1, 2004, through July 1, 2007, operations component rate allocations, and so forth.

(b) Beginning July 1, 1999, and for all subsequent July 1st nonrebased operations component rate allocations shall be adjusted ((~~annually~~)) for economic trends and conditions by a ((~~factor or factors defined in the biennial appropriations act~~)) change in the nursing home price input without capital costs published by the health care financing administration of the department of health and human services (HCFA index). The period to be used to measure the HCFA index increase or decrease shall be the calendar year immediately preceding the July 1st nonrebased rate period.

(c) Beginning July 1, 2001, and for all subsequent July 1st rebased operations component rate allocations, the rebase period cost report data shall be adjusted for economic trends and conditions by the change in the HCFA index for the calendar year that immediately precedes the July 1st rebased rate period, multiplied by a factor of 2.0.

((~~(8) For July 1, 1998, through September 30, 1998, a facility's property and return on investment component rates shall be the facility's June 30, 1998, property and return on investment component rates, without increase. For October 1, 1998, through June 30, 1999, a facility's property and return on investment component rates shall be rebased utilizing 1997 adjusted cost report data covering at least six months of data.~~

~~(9)~~)) (7) Total payment rates under the nursing facility medicaid payment system shall not exceed facility rates charged to the general public for comparable services.

((~~(10)~~)) (8) Medicaid contractors shall pay to all facility staff a minimum wage of the greater of ((~~five dollars and fifteen cents per hour~~)) the state or the federal minimum wage. To the extent that the percentage change in the HCFA index, specified in this section, is less than the annual percentage change in the state or federal minimum wage requirement, and notwithstanding any peer group cost limitations, the department shall prospectively adjust each contractor's rate component to fund the medicaid share of any such increase in the minimum wage

1 amount, including any related parity wage adjustments that a contractor
2 may make. However, any related parity wage adjustment that a
3 contractor may make as a result of an increase in the state or federal
4 minimum wage, the medicaid share shall be no greater than the
5 percentage change between the federal or state required minimum wage
6 increase and only to the extent that the percentage change in the
7 minimum wage exceeds the percentage change in the HCFA index as
8 specified in this section.

9 ((~~(11)~~)) (9) The department shall establish in rule procedures,
10 principles, and conditions for determining component rate allocations
11 for facilities in circumstances not directly addressed by this chapter,
12 including but not limited to: The need to prorate inflation for
13 partial-period cost report data, newly constructed facilities, existing
14 facilities entering the medicaid program for the first time or after a
15 period of absence from the program, existing facilities with expanded
16 new bed capacity, existing medicaid facilities following a change of
17 ownership of the nursing facility business, facilities banking beds or
18 converting beds back into service, facilities having less than six
19 months of either resident assessment, cost report data, or both, under
20 the current contractor prior to rate setting, and other circumstances.

21 ((~~(12)~~)) (10) The department shall establish in rule procedures,
22 principles, and conditions, including necessary threshold costs, for
23 adjusting rates to reflect capital improvements or new requirements
24 imposed by the department or the federal government. Any such rate
25 adjustments are subject to the provisions of RCW 74.46.421.

26 (11) Any rebate, refund, dividend, or payment made to a contractor,
27 during a rebase cost report period, by any state agency, as defined in
28 chapter 34.05 RCW, shall not be used to establish any peer group cost
29 limitations or to determine a facility specific rate when the rebate,
30 refund, dividend, or payment is not reasonably expected to reoccur
31 during each immediately succeeding nonrebase cost report period,
32 excluding any rebates distributed under the retrospective rating
33 program under chapter 51.16 RCW.

34 (12) Prior to the July 1st rate period, the department shall
35 recalculate any medians that may be affected by removing the home
36 office or central office cost limitation under RCW 74.46.410 and taxes
37 paid under section 8 of this act.

38 (13) Following each July 1st rebased rate period, the department
39 shall, by the immediately following July 1st nonrebased rate period,

recalculate any medians affected by any appeals or errors or omissions made under this chapter and shall make any necessary rate adjustments.

Sec. 4. RCW 74.46.506 and 1998 c 322 s 25 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) Beginning October 1, 1998, the department shall determine and update quarterly 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 calendar quarter. 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 ((~~1996 and 1999, for rate periods~~)) as specified in RCW 74.46.431(4)(a).

(5) Beginning October 1, 1998, 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, consistent with the following:

1 (a) Reduce total direct care costs reported by each nursing
2 facility for the applicable cost report period specified in RCW
3 74.46.431(4)(a) to reflect any department adjustments, and to eliminate
4 reported resident therapy costs and adjustments, in order to derive the
5 facility's total allowable direct care cost;
6 (b) Divide each facility's total allowable direct care cost by its
7 adjusted resident days for the same report period, increased if
8 necessary to a minimum occupancy of eighty-five percent; that is, the
9 greater of actual or imputed occupancy at eighty-five percent of
10 licensed beds <u>or, if applicable, use its resident days under RCW</u>
11 <u>74.46.431(2)(b)</u>, to derive the facility's allowable direct care cost
12 per resident day;
13 (c) Adjust the facility's per resident day direct care cost by the
14 applicable factor specified in RCW 74.46.431(4) (b) and (c) to derive
15 its adjusted allowable direct care cost per resident day;
16 (d) Divide each facility's adjusted allowable direct care cost per
17 resident day by the facility average case mix index for the applicable
18 quarters specified by RCW 74.46.501(7)(b) to derive the facility's
19 allowable direct care cost per case mix unit;
20 (e) Divide nursing facilities into two peer groups: Those located
21 in metropolitan statistical areas as determined and defined by the
22 United States office of management and budget or other appropriate
23 agency or office of the federal government, and those not located in a
24 metropolitan statistical area;
25 (f) Array separately the allowable direct care cost per case mix
26 unit for all metropolitan statistical area and for all nonmetropolitan
27 statistical area facilities, and determine the median allowable direct
28 care cost per case mix unit for each peer group;
29 (g) Except as provided in (k) of this subsection, from October 1,
30 1998, through June 30, 2000, determine each facility's quarterly direct
31 care component rate as follows:
32 (i) Any facility whose allowable cost per case mix unit is less
33 than eighty-five percent of the facility's peer group median
34 established under (f) of this subsection shall be assigned a cost per
35 case mix unit equal to eighty-five percent of the facility's peer group
36 median, and shall have a direct care component rate allocation equal to
37 the facility's assigned cost per case mix unit multiplied by that
38 facility's medicaid average case mix index from the applicable quarter
39 specified in RCW 74.46.501(7)(c);

(ii) Any facility whose allowable cost per case mix unit is greater than one hundred fifteen percent of the peer group median established under (f) of this subsection shall be assigned a cost per case mix unit equal to one hundred fifteen 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 quarter specified in RCW 74.46.501(7)(c);

(iii) Any facility whose allowable cost per case mix unit is between eighty-five and one hundred fifteen percent of the peer group median established under (f) 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 quarter specified in RCW 74.46.501(7)(c);

(h) Except as provided in (k) of this subsection, from July 1, 2000, through June 30, 2002, determine each facility's quarterly direct care component rate as follows:

(i) Any facility whose allowable cost per case mix unit is less than ninety percent of the facility's peer group median established under (f) of this subsection shall be assigned a cost per case mix unit equal to ninety percent of the facility's 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 quarter specified in RCW 74.46.501(7)(c);

(ii) Any facility whose allowable cost per case mix unit is greater than one hundred ten percent of the peer group median established under (f) of this subsection shall be assigned a cost per case mix unit equal to one hundred ten 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 quarter specified in RCW 74.46.501(7)(c);

(iii) Any facility whose allowable cost per case mix unit is between ninety and one hundred ten percent of the peer group median established under (f) 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 quarter specified in RCW 74.46.501(7)(c);

(i) From July 1, 2002, through June 30, 2004, determine each facility's quarterly direct care component rate as follows:

(i) Any facility whose allowable cost per case mix unit is less than ninety-five percent of the facility's peer group median established under (f) of this subsection shall be assigned a cost per case mix unit equal to ninety-five percent of the facility's 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 quarter specified in RCW 74.46.501(7)(c);

(ii) Any facility whose allowable cost per case mix unit is greater than one hundred five percent of the peer group median established under (f) of this subsection shall be assigned a cost per case mix unit equal to one hundred five 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 quarter specified in RCW 74.46.501(7)(c);

(iii) Any facility whose allowable cost per case mix unit is between ninety-five and one hundred five percent of the peer group median established under (f) 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 quarter specified in RCW 74.46.501(7)(c);

(j) Beginning July 1, 2004, determine each facility's quarterly direct care component rate by multiplying the facility's peer group median allowable direct care cost per case mix unit by that facility's medicaid average case mix index from the applicable quarter as specified in RCW 74.46.501(7)(c).

(k)(i) Between October 1, 1998, and June 30, 2000, the department shall compare each facility's direct care component rate allocation calculated under (g) of this subsection with the facility's nursing services component rate in effect on June 30, 1998, less therapy costs, plus any exceptional care offsets as reported on the 1997 cost report divided by the number of medicaid days as reported on the 1997 cost report, adjusted for economic trends and conditions ((~~as provided in RCW 74.46.431~~)) using a factor of two percent. A facility shall receive the higher of the two rates;

1 (ii) Between July 1, 2000, and June 30, 2002, the department shall
2 compare each facility's direct care component rate allocation
3 calculated under (h) of this subsection with the facility's direct care
4 component rate in effect on June 30, 2000. A facility shall receive
5 the higher of the two rates.

6 (6) The direct care component rate allocations calculated in
7 accordance with this section shall be adjusted to the extent necessary
8 to comply with RCW 74.46.421. If the department determines that the
9 weighted average rate allocations for all rate components for all
10 facilities is likely to exceed the weighted average total rate
11 specified in the state biennial appropriations act, the department
12 shall adjust the rate allocations calculated in this section
13 proportional to the amount by which the total weighted average rate
14 allocations would otherwise exceed the budgeted level. Such
15 adjustments shall only be made prospectively, not retrospectively.

16 (7) The department is authorized to increase the direct care
17 component rate allocation calculated under subsection (5) of this
18 section for residents who have unmet exceptional care needs. For
19 purposes of authorizing additional payment under this subsection,
20 exceptional care needs shall include ventilator-dependent residents,
21 residents with traumatic brain injury, residents who are behaviorally
22 challenged, residents who are morbidly obese, and other exceptional
23 care categories as may be defined, in rule, by the department. The
24 department may, by rule, establish criteria and methods of exceptional
25 care payment.

26 NEW SECTION. **Sec. 5.** A new section is added to chapter 74.09 RCW
27 to read as follows:

28 (1)(a) Therapy care payment shall relate to the provision of one-
29 on-one therapy provided to medicaid residents by a qualified therapist,
30 as defined in this chapter, or by a qualified therapists' assistant,
31 and shall include copayment or deductible amounts under the medicare
32 program.

33 (b) Costs associated with the provision of therapy care that are
34 paid privately, by commercial insurance, or the federal medicare
35 program, except for copayment or deductible amounts, shall be excluded
36 from payment under this chapter.

37 (c) Consultation services shall be included in the therapy care
38 payment method and shall, at a minimum, include consultant costs

related to the preparation and presentation of in-service training to nontherapy staff members, time spent with staff setting up nonchargeable feeding programs or their equivalent and time spent training nonchargeable routine restorative aides.

(2) Beginning July 1, 1999, the department shall pay for therapy care based on claims submitted. Only claims submitted by an eligible therapy services provider, using the UB-92 claim form for physical, speech, or occupational therapy services, shall be paid. An eligible therapy services provider shall be the individual or entity licensed to provide the therapy service, a nursing facility licensed under chapter 18.51 RCW, or an individual or entity or certified to participate in the medicare program. Payment shall be limited to medically necessary services.

(a) Payment for physical, speech, or occupational therapy, by therapy type, shall be based on the lower of the eligible therapy provider's usual and customary billed charge or the maximum allowable fee amounts established by the department's medical assistance administration for outpatient hospital services.

(b) Payment for mental health, mental retardation, and respiratory therapy, by therapy type, shall be based on a fee schedule. The fee schedule shall be developed by the department in consultation with the eligible therapy services providers. The fee schedule shall be in an amount or amounts sufficient to encourage the appropriate use of such therapy care.

(3)(a) The department may, by rule, establish a utilization threshold, expressed either as dates of service per resident or in dollars per resident, or both, which if exceeded will result in a case management review of the medical necessity for the therapy care. In establishing the case management utilization threshold or thresholds, the department shall consult with eligible therapy services providers.

(b) The department shall complete its case management utilization review, if required, promptly and shall notify the eligible therapy service provider of its decision no later than ten days following the date on which the necessary documentation demonstrating medical necessity for the therapy was submitted.

(4) The department shall by rule establish procedures for billing for therapy care, including the copayment or deductible amounts under the medicare program. Claims for payment shall be submitted, by the eligible therapy service provider, to the department's medical

assistance administration no later than one hundred twenty days after providing the therapy care.

(5) The department shall reimburse the eligible therapy service provider for all allowable therapy care within twenty days following the submission of claims.

(6) Nothing in this section shall interfere with the department's ability to contract with and pay for physical medicine and rehabilitation services, level B, under the department's existing program requirements.

Sec. 6. RCW 74.46.515 and 1998 c 322 s 27 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) Beginning October 1, 1998, 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)~~)) (5)(a).

(3) Beginning July 1, 1999, to determine each facility's support services component rate allocation, the department shall:

(a) Array facilities' adjusted support services costs per adjusted resident day for each facility from facilities' cost reports from the applicable report year, for facilities located within a metropolitan statistical area, and for those not located in any metropolitan statistical area 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 metropolitan statistical area or nonmetropolitan statistical area, plus 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)~~)) (5)(b) and (c); and

(d) Use a resident occupancy level of eighty-five percent subsequent to the decrease or increase in licensed bed capacity if a contractor elects to bank licensed beds or to convert banked beds to active service under chapter 70.38 RCW.

(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. If the department determines that the weighted average rate allocations for all rate components for all facilities is likely to exceed the weighted average total rate specified in the state biennial appropriations act, the department shall adjust the rate allocations calculated in this section proportional to the amount by which the total weighted average rate allocations would otherwise exceed the budgeted level. Such adjustments shall only be made prospectively, not retrospectively.

Sec. 7. RCW 74.46.521 and 1998 c 322 s 28 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 taxes paid under section 8 of this act, direct care, therapy care, support services, property, and return on investment.

(2) Beginning October 1, 1998, 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)~~)) (6)(a).

(3) Beginning July 1, 1999, to determine each facility's operations component rate the department shall:

(a) Array facilities' adjusted general operations costs per adjusted resident day for each facility from facilities' cost reports from the applicable report year, for facilities located within a metropolitan statistical area and for those not located in a metropolitan statistical area and determine the median adjusted cost for each peer group;

(b) Set each facility's operations component rate at the lower of the facility's per resident day adjusted operations costs from the applicable cost report period or the adjusted median per resident day general operations cost for that facility's peer group, metropolitan statistical area or nonmetropolitan statistical area; ((~~and~~))

(c) Use a resident occupancy level of eighty-five percent subsequent to the decrease or increase in licensed bed capacity if a

contractor elects to bank licensed beds or to convert banked beds to active service under chapter 70.38 RCW; and

(d) Adjust each facility's operations component rate for economic trends and conditions as provided in RCW 74.46.431((~~(7)(b)~~)) (5) (b) and (c).

(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. If the department determines that the weighted average rate allocations for all rate components for all facilities is likely to exceed the weighted average total rate specified in the state biennial appropriations act, the department shall adjust the rate allocations calculated in this section proportional to the amount by which the total weighted average rate allocations would otherwise exceed the budgeted level. Such adjustments shall only be made prospectively, not retrospectively.

NEW SECTION. **Sec. 8.** A new section is added to chapter 74.46 RCW to read as follows:

(1) The tax component rate allocation corresponds to the real estate, personal property, and business and occupation taxes assessed by the department of revenue against a nursing facility.

(2) Beginning July 1, 1999, and on each July 1st thereafter, the department shall determine each medicaid nursing facility's tax component rate allocation, as applicable, using cost report data from the immediately preceding calendar year.

(3) The tax component rate allocation shall be an amount that is proportionate to the nursing facility's medicaid resident days to total actual days during the immediately preceding cost report year.

(4) The tax component rate allocations calculated in accordance with this section shall be adjusted to the extent necessary to comply with RCW 74.46.421. If the department determines that the weighted average rate allocations for all rate components for all facilities is likely to exceed the weighted average total rate specified in the state biennial appropriations act, the department shall adjust the rate allocations calculated in this section proportional to the amount by which the total weighted average rate allocations would otherwise exceed the budgeted level. Such adjustments shall only be made prospectively, not retrospectively.

1 NEW SECTION. **Sec. 9.** RCW 74.46.511 and 1998 c 322 s 26 are each
2 repealed.

--- END ---