H-1850.1

HOUSE BILL 2152

State of Washington 56th Legislature 1999 Regular Session

By Representatives Cody, Parlette, Van Luven, Conway and Edmonds

Read first time 02/17/1999. Referred to Committee on Health Care.

AN ACT Relating to exceptional care and therapy care payment rates; amending RCW 74.46.506; and adding a new section to chapter 74.09 RCW.

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

Sec. 1. 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:

(a) Reduce 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, increased if necessary to a minimum occupancy of eighty-five percent; that is, the greater of actual or imputed occupancy at eighty-five percent of licensed beds or, if applicable, use its resident days under RCW 74.46.431(2)(b), to derive the facility's allowable direct care cost per resident day;

(c) Adjust the facility's per resident day direct care cost by the applicable factor specified in RCW 74.46.431(4) (b) and (c) to derive its adjusted allowable direct care cost per resident day;

(d) 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(7)(b) to derive the facility's allowable direct care cost per case mix unit;

(e) Divide nursing facilities into two peer groups: Those located in metropolitan statistical areas as determined and defined by the United States office of management and budget or other appropriate agency or office of the federal government, and those not located in a metropolitan statistical area;

(f) Array separately the allowable direct care cost per case mix unit for all metropolitan statistical area and for all nonmetropolitan statistical area facilities, and determine the median allowable direct care cost per case mix unit for each peer group;

(g) Except as provided in (k) of this subsection, from October 1, 1998, through June 30, 2000, determine each facility's quarterly direct care component rate as follows:

(i) Any facility whose allowable cost per case mix unit is less than eighty-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 eighty-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 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;

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

(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. 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.

(7) The department is authorized to increase the direct care component rate allocation calculated under subsection (5) of this section for residents who have unmet exceptional care needs. For purposes of authorizing additional payment under this subsection,

exceptional care needs shall include ventilator-dependent residents, residents with traumatic brain injury, residents who are behaviorally challenged, residents who are morbidly obese, and other exceptional care categories as may be defined, in rule, by the department. The department may, by rule, establish criteria and methods of exceptional care payment.

NEW SECTION. **Sec. 2.** A new section is added to chapter 74.09 RCW to read as follows:

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

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

(c) Consultation services shall be included in the therapy care 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.

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