CERTIFICATION OF ENROLLMENT

SUBSTITUTE HOUSE BILL 2152

Chapter 181, Laws of 1999

56th Legislature
1999 Regular Session

EXCEPTIONAL CARE AND THERAPY CARE PAYMENT RATES

EFFECTIVE DATE: 7/25/99

Passed by the House April 8, 1999
Yeas 96 Nays 0

CLYDE BALLARD
Speaker of the House of Representatives

FRANK CHOPP
Speaker of the House of Representatives

Passed by the Senate April 16, 1999
Yeas 48 Nays 0

BRAD OWEN
President of the Senate

Approved May 5, 1999

GARY LOCKE
Governor of the State of Washington

CERTIFICATE

We, Dean R. Foster and Timothy A. Martin, Co-Chief Clerks of the House of Representatives of the State of Washington, do hereby certify that the attached is **SUBSTITUTE HOUSE BILL 2152** as passed by the House of Representatives and the Senate on the dates hereon set forth.

DEAN R. FOSTER
Chief Clerk

TIMOTHY A. MARTIN
Chief Clerk

FILED

May 5, 1999 - 3:59 p.m.

Secretary of State
State of Washington

H-2093.4

SUBSTITUTE HOUSE BILL 2152

Passed Legislature - 1999 Regular Session

State of Washington 56th Legislature 1999 Regular Session

By House Committee on Health Care (originally sponsored by Representatives Cody, Parlette, Van Luven, Conway and Edmonds)

Read first time 03/02/1999.

AN ACT Relating to exceptional care and therapy care payment rates; amending RCW 74.46.506 and 74.46.511; adding a new section to chapter 74.46 RCW; and providing an expiration date.

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, 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~~)) September 30, 1998, less therapy costs, plus any exceptional care offsets as reported on the cost report, adjusted for economic trends and conditions as provided in RCW 74.46.431. 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) Payments resulting from increases in direct care component rates, granted under authority of section 2(1) of this act 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.

NEW SECTION. **Sec. 2.** A new section is added to chapter 74.46 RCW to read as follows:

(1)(a) The department is authorized to increase the direct care component rate allocation calculated under RCW 74.46.506(5) for residents who have unmet exceptional care needs as determined by the department in rule. The department may, by rule, establish criteria, patient categories, and methods of exceptional care payment.

(b) The department shall submit a report to the health care and fiscal committees of the legislature by December 12, 2002, that addresses:

(i) The number of individuals on whose behalf exceptional care payments have been made under this section, their diagnosis, and the amount of the payments; and

(ii) An assessment as to whether the availability of exceptional care payments resulted in more expedient placement of residents into nursing homes and fewer and/or shorter hospitalizations.

(2)(a) The department shall by January 1, 2000, adopt rules and implement a system of exceptional care payments for therapy care.

(i) Payments may be made on behalf of facility residents who are under age sixty-five, not eligible for medicare, and can achieve significant progress in their functional status if provided with intensive therapy care services.

(ii) Payment under this subsection is limited to no more than twelve facilities that have demonstrated excellence in therapy care, based upon criteria defined by rule. A facility accredited by the commission for accreditation of rehabilitation facilities (CARF) shall be deemed to meet the criteria for demonstrated excellence in therapy care. However, CARF accreditation is not required for payment under this subsection.

(iii) Payments may be made only after approval of a rehabilitation plan of care for each resident on whose behalf a payment is made under this subsection, and each resident’s progress must be periodically monitored.

(b) The department shall submit a report to the health care and fiscal committees of the legislature by December 12, 2002, that addresses:

(i) The number of individuals on whose behalf therapy payments were made under this section, and the amount of the payments; and

(ii) An assessment as to whether the availability of exceptional care payments for therapy care resulted in substantial progress in residents' functional status, more expedient placement of residents into less expensive settings, or other long-term cost savings.

(3) This section expires June 30, 2003.

Sec. 3. RCW 74.46.511 and 1998 c 322 s 26 are each amended to read as follows:

(1) The therapy care component rate allocation corresponds to the provision of medicaid one-on-one therapy provided by a qualified therapist as defined in this chapter, including therapy supplies and therapy consultation, for one day for one medicaid resident of a nursing facility. The therapy care component rate allocation for October 1, 1998, through June 30, 2001, shall be based on adjusted therapy costs and days from calendar year 1996. The therapy component rate allocation for July 1, 2001, through June 30, 2004, shall be based on adjusted therapy costs and days from calendar year 1999. The therapy care component rate shall be adjusted for economic trends and conditions as specified in RCW 74.46.431(5)(b), and shall be determined in accordance with this section.

(2) In rebasing, as provided in RCW 74.46.431(5)(a), the department shall take from the cost reports of facilities the following reported information:

(a) Direct one-on-one therapy charges for all residents by payer including charges for supplies;

(b) The total units or modules of therapy care for all residents by type of therapy provided, for example, speech or physical. A unit or module of therapy care is considered to be fifteen minutes of one-on-one therapy provided by a qualified therapist or support personnel; and

(c) Therapy consulting expenses for all residents.

(3) The department shall determine for all residents the total cost per unit of therapy for each type of therapy by dividing the total adjusted one-on-one therapy expense for each type by the total units provided for that therapy type.

(4) The department shall divide medicaid nursing facilities in this state into two peer groups:

(a) Those facilities located within a metropolitan statistical area; and

(b) Those not located in a metropolitan statistical area.

Metropolitan statistical areas and nonmetropolitan statistical areas shall be as determined by the United States office of management and budget or other applicable federal office. The department shall array the facilities in each peer group from highest to lowest based on their total cost per unit of therapy for each therapy type. The department shall determine the median total cost per unit of therapy for each therapy type and add ten percent of median total cost per unit of therapy. The cost per unit of therapy for each therapy type at a nursing facility shall be the lesser of its cost per unit of therapy for each therapy type or the median total cost per unit plus ten percent for each therapy type for its peer group.

(5) The department shall calculate each nursing facility's therapy care component rate allocation as follows:

(a) To determine the allowable total therapy cost for each therapy type, the allowable cost per unit of therapy for each type of therapy shall be multiplied by the total therapy units for each type of therapy;

(b) The medicaid allowable one-on-one therapy expense shall be calculated taking the allowable total therapy cost for each therapy type times the medicaid percent of total therapy charges for each therapy type;

(c) The medicaid allowable one-on-one therapy expense for each therapy type shall be divided by total adjusted medicaid days to arrive at the medicaid one-on-one therapy cost per patient day for each therapy type;

(d) The medicaid one-on-one therapy cost per patient day for each therapy type shall be multiplied by total adjusted patient days for all residents to calculate the total allowable one-on-one therapy expense. The lesser of the total allowable therapy consultant expense for the therapy type or a reasonable percentage of allowable therapy consultant expense for each therapy type, as established in rule by the department, shall be added to the total allowable one-on-one therapy expense to determine the allowable therapy cost for each therapy type;

(e) The allowable therapy cost for each therapy type shall be added together, the sum of which shall be the total allowable therapy expense for the nursing facility;

(f) The total allowable therapy expense will be divided by the greater of adjusted total patient days from the cost report on which the therapy expenses were reported, or patient days at eighty-five percent occupancy of licensed beds. The outcome shall be the nursing facility's therapy care component rate allocation.

(6) The therapy 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 therapy care component rate shall be suspended for medicaid residents in qualified nursing facilities designated by the department who are receiving therapy paid by the department outside the facility daily rate under section 2(2) of this act.

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Passed the Senate April 16, 1999.
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