Z-0299.2

SENATE BILL 5677

State of Washington 57th Legislature 2001 Regular Session

By Senator Thibaudeau; by request of Department of Social and Health Services

Read first time 01/30/2001. Referred to Committee on Health & Long-Term Care.

AN ACT Relating to adjusting nursing home payments to enhance direct care; amending RCW 74.46.165, 74.46.410, 74.46.431, 74.46.433, 74.46.435, 74.46.437, 74.46.501, 74.46.515, 74.46.521, and 74.46.711; reenacting and amending RCW 74.46.506 and 74.46.511; adding a new section to chapter 74.46 RCW; creating a new section; repealing RCW 74.46.280 and 74.46.908; providing effective dates; and declaring an emergency.

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

Sec. 1. RCW 74.46.165 and 1998 c 322 s 10 are each amended to read as follows:

(1) Contractors shall be required to submit with each annual nursing facility cost report a proposed settlement report showing underspending or overspending in each component rate during the cost report year on a per-resident day basis. The department shall accept or reject the proposed settlement report, explain any adjustments, and issue a revised settlement report if needed.

(2) Contractors shall not be required to refund payments made in the operations, variable return, property, and ((~~return on investment~~))

financing allowance component rates in excess of the adjusted costs of providing services corresponding to these components.

(3) The facility will return to the department any overpayment amounts in each of the direct care, therapy care, and support services rate components that the department identifies following the audit and settlement procedures as described in this chapter, provided that the contractor may retain any overpayment that does not exceed 1.0% of the facility's direct care, therapy care, and support services component rate. However, no overpayments may be retained in a cost center to which savings have been shifted to cover a deficit, as provided in subsection (4) of this section. Facilities that are not in substantial compliance for more than ninety days, and facilities that provide substandard quality of care at any time, during the period for which settlement is being calculated, will not be allowed to retain any amount of overpayment in the facility's direct care, therapy care, and support services component rate. The terms "not in substantial compliance" and "substandard quality of care" shall be defined by federal survey regulations.

(4) Determination of unused rate funds, including the amounts of direct care, therapy care, and support services to be recovered, shall be done separately for each component rate, and, except as otherwise provided in this subsection, neither costs nor rate payments shall be shifted from one component rate or corresponding service area to another in determining the degree of underspending or recovery, if any. ((~~However,~~)) In computing a preliminary or final settlement, savings in the support services cost center ((~~may~~)) shall be shifted to cover a deficit in the direct care or therapy cost centers up to the amount of any savings, but no more than twenty percent of the support services component rate may be shifted. Savings in direct care and therapy care may be shifted between these two cost centers up to the amount of savings in each, regardless of the percentage of either component rate shifted. Contractor-retained overpayments up to one percent of direct care, therapy care, and support services rate components, as authorized in subsection (3) of this section, shall be calculated and applied after all shifting is completed. ((~~Not more than twenty percent of the rate in a cost center may be shifted.~~))

(5) Total and component payment rates assigned to a nursing facility, as calculated and revised, if needed, under the provisions of this chapter and those rules as the department may adopt, shall

represent the maximum payment for nursing facility services rendered to medicaid recipients for the period the rates are in effect. No increase in payment to a contractor shall result from spending above the total payment rate or in any rate component.

(6) RCW 74.46.150 through 74.46.180, and rules adopted by the department prior to July 1, 1998, shall continue to govern the medicaid settlement process for periods prior to October 1, 1998, as if these statutes and rules remained in full force and effect.

(7) For calendar year 1998, the department shall calculate split settlements covering January 1, 1998, through September 30, 1998, and October 1, 1998, through December 31, 1998. For the period beginning October 1, 1998, rules specified in this chapter shall apply. The department shall, by rule, determine the division of calendar year 1998 adjusted costs for settlement purposes.

Sec. 2. RCW 74.46.410 and 1998 c 322 s 17 are each amended to read as follows:

(1) Costs will be unallowable if they are not documented, necessary, ordinary, and related to the provision of care services to authorized patients.

(2) Unallowable costs include, but are not limited to, the following:

(a) Costs of items or services not covered by the medical care program. Costs of such items or services will be unallowable even if they are indirectly reimbursed by the department as the result of an authorized reduction in patient contribution;

(b) Costs of services and items provided to recipients which are covered by the department's medical care program but not included in the medicaid per-resident day payment rate established by the department under this chapter;

(c) Costs associated with a capital expenditure subject to section 1122 approval (part 100, Title 42 C.F.R.) if the department found it was not consistent with applicable standards, criteria, or plans. If the department was not given timely notice of a proposed capital expenditure, all associated costs will be unallowable up to the date they are determined to be reimbursable under applicable federal regulations;

(d) Costs associated with a construction or acquisition project requiring certificate of need approval, or exemption from the

requirements for certificate of need for the replacement of existing nursing home beds, pursuant to chapter 70.38 RCW if such approval or exemption was not obtained;

(e) Interest costs other than those provided by RCW 74.46.290 on and after January 1, 1985;

(f) Salaries or other compensation of owners, officers, directors, stockholders, partners, principals, participants, and others associated with the contractor or its home office, including all board of directors' fees and, in the case of publicly operated facilities, commissioners' fees, for any purpose, except reasonable compensation paid for service related to patient care;

(g) Costs in excess of limits or in violation of principles set forth in this chapter;

(h) Costs resulting from transactions or the application of accounting methods which circumvent the principles of the payment system set forth in this chapter;

(i) Costs applicable to services, facilities, and supplies furnished by a related organization in excess of the lower of the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere;

(j) Bad debts of Title XIX or non-Title XIX recipients((~~. Bad debts of Title XIX recipients are allowable if the debt is related to covered services, it arises from the recipient's required contribution toward the cost of care, the provider can establish that reasonable collection efforts were made, the debt was actually uncollectible when claimed as worthless, and sound business judgment established that there was no likelihood of recovery at any time in the future~~));

(k) Charity and courtesy allowances;

(l) Cash, assessments, or other contributions, excluding dues, to charitable organizations, professional organizations, trade associations, or political parties, and costs incurred to improve community or public relations;

(m) Vending machine expenses;

(n) Expenses for barber or beautician services not included in routine care;

(o) Funeral and burial expenses;

(p) Costs of gift shop operations and inventory;

(q) Personal items such as cosmetics, smoking materials, newspapers and magazines, and clothing, except those used in patient activity programs;

(r) Fund-raising expenses, except those directly related to the patient activity program;

(s) Penalties and fines;

(t) Expenses related to telephones, ((~~televisions,~~)) radios, and similar appliances in patients' private accommodations;

(u) Federal, state, and other income taxes;

(v) Costs of special care services except where authorized by the department;

(w) Expenses of an employee benefit not in fact made available to all employees on an equal or fair basis, for example, key-man insurance and other insurance or retirement plans;

(x) Expenses of profit-sharing plans;

(y) Expenses related to the purchase and/or use of private or commercial airplanes which are in excess of what a prudent contractor would expend for the ordinary and economic provision of such a transportation need related to patient care;

(z) Personal expenses and allowances of owners or relatives;

(aa) All expenses of maintaining professional licenses or membership in professional organizations;

(bb) Costs related to agreements not to compete;

(cc) Amortization of goodwill, lease acquisition, or any other intangible asset, whether related to resident care or not, and whether recognized under generally accepted accounting principles or not;

(dd) Expenses related to vehicles which are in excess of what a prudent contractor would expend for the ordinary and economic provision 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;

(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; and

(yy) All nursing facility management fees and costs.

Sec. 3. RCW 74.46.431 and 1999 c 353 s 4 are each amended to read as follows:

(1) Effective July 1, 1999, nursing facility medicaid payment rate allocations shall be facility-specific and shall have seven components: Direct care, therapy care, support services, operations, property, financing allowance, and variable return. 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) All component rate allocations shall be based upon a minimum facility occupancy of ((~~eighty-five~~)) ninety percent of licensed beds, regardless of how many beds are set up or in use.

(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. 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.

(b) Direct care component rate allocations based on 1996 cost report data shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. 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) Direct care component rate allocations based on 1999 cost report data shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. 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) Support services component rate allocations shall be established using adjusted cost report data covering at least six months. 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.

(b) 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.

(7)(a) Operations component rate allocations shall be established using adjusted cost report data covering at least six months. 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.

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

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

(10) Medicaid contractors shall pay to all facility staff a minimum wage of the greater of ((~~five dollars and fifteen cents per hour~~)) the state minimum wage or the federal minimum wage.

(11) 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: The need to prorate inflation 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 banking beds or converting beds back into service, 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.

(12) 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.

Sec. 4. RCW 74.46.433 and 1999 c 353 s 9 are each amended to read as follows:

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

(a) The variable return array and percentage assigned at the October 1, 1998, rate setting shall remain in effect until June 30, 2001, and the variable return array and percentage assigned at the July 1, 2001, rate setting shall remain in effect until June 30, 2004.

(b) To calculate the array of facilities for the July 1, 2001, rate setting, the department, without using peer groups, shall first rank all facilities in numerical order from highest to lowest according to each facility's examined and documented, but unlidded, combined direct care, therapy care, support services, and operations per resident day cost from the 1999 cost report period. However, before being combined with other per resident day costs and ranked, a facility's direct care cost per resident day shall be adjusted to reflect its facility average case mix index, to be averaged from the four calendar quarters of 1999, weighted by the facility's resident days from each quarter, under RCW 74.46.501(7)(b)(ii). The array shall then be divided into four quartiles, each containing, as nearly as possible, an equal number of facilities, and four percent shall be assigned to facilities in the lowest quartile, three percent to facilities in the next lowest quartile, two percent to facilities in the next highest quartile, and one percent to facilities in the highest quartile.

(c) The department shall ((~~then~~)) compute the variable return allowance by multiplying ((~~the appropriate~~)) a facility's assigned percentage ((~~amounts, which shall not be less than one percent and not greater than four percent,~~)) by the sum of the facility's direct care, therapy care, support services, and operations ((~~rate~~)) component((~~s~~)) rates determined in accordance with this chapter and rules adopted by the department. ((~~The percentage amounts will be based on groupings of facilities according to the rankings prescribed in (a) of this subsection, as applicable. Those groups of facilities with lower per diem costs shall receive higher percentage amounts than those with higher per diem costs.~~))

(2) The variable return rate allocation calculated in accordance with this section shall be adjusted to the extent necessary to comply with RCW 74.46.421.

Sec. 5. RCW 74.46.435 and 1999 c 353 s 10 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 RCW 74.46.310 through 74.46.380, 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 for the facility in the prior period or resident days as calculated on ((~~eighty-five~~)) ninety percent facility occupancy. 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 or October 1st as applicable, 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) For the purpose of calculating a nursing facility's property component rate, if a contractor elects to bank licensed beds or to convert banked beds to active service, under chapter 70.38 RCW, the department shall use the facility's anticipated resident occupancy level subsequent to the decrease or increase in licensed bed capacity. However, in no case shall the department use less than ((~~eighty-five~~)) ninety percent occupancy of the facility's licensed bed capacity after banking or conversion.

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

Sec. 6. RCW 74.46.437 and 1999 c 353 s 11 are each amended to read as follows:

(1) Beginning July 1, 1999, 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 shall be determined by multiplying the net invested funds of each facility by .10, 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-five~~)) ninety percent facility occupancy. However, assets acquired on or after May 17, 1999, shall be grouped in a separate financing allowance calculation that shall be multiplied by .085. The financing allowance factor of .085 shall not be applied to the net invested funds pertaining to new construction or major renovations receiving certificate of need approval or an exemption from certificate of need requirements under chapter 70.38 RCW, or to working drawings that have been submitted to the department of health for construction review approval, prior to May 17, 1999. 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 financing allowance shall be adjusted to the greater of the anticipated resident day level or ((~~eighty-five~~)) ninety percent of the new licensed bed capacity.

(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 RCW 74.46.330, 74.46.350, 74.46.360, 74.46.370, and 74.46.380, 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 shall 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 shall be 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 shall be 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 shall have the authority to determine an amount for net invested funds based on an appraisal conducted according to RCW 74.46.360(1).

(4) For the purpose of calculating a nursing facility's financing allowance component rate, if a contractor elects to bank licensed beds or to convert banked beds to active service, under chapter 70.38 RCW, the department shall use the facility's anticipated resident occupancy level subsequent to the decrease or increase in licensed bed capacity. However, in no case shall the department use less than ((~~eighty-five~~)) ninety percent occupancy of the facility's licensed bed capacity after banking or conversion.

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

Sec. 7. RCW 74.46.501 and 1998 c 322 s 24 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 (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)(a) 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 follows:

(i) If a resident's initial assessment for a first stay or a return stay in the nursing facility is timely completed and transmitted to the department by the cutoff date under state and federal requirements and

as described in subsection (5) of this section, the start date shall be the later of either the first day of the quarter or the resident's facility admission or readmission date;

(ii) If a resident's significant change, quarterly, or annual assessment is timely completed and transmitted to the department by the cutoff date under state and federal requirements and as described in subsection (5) of this section, the start date shall be the date the assessment is completed;

(iii) If a resident's significant change, quarterly, or annual assessment is not timely completed and transmitted to the department by the cutoff date under state and federal requirements and as described in subsection (5) of this section, the start date shall be the due date for the assessment.

(b) If state or federal rules require more frequent assessment, the same principles for determining the start date of a resident's classification in a particular case mix group set forth in subsection (4)(a) of this section shall apply.

(c) In calculating the number of days a resident is classified into a particular case mix group, the department shall determine an end date for calculating case mix grouping periods as follows:

(i) If a resident is discharged before the end of the applicable quarter, the end date shall be the day before discharge;

(ii) If a resident is not discharged before the end of the applicable quarter, the end date shall be the last day of the quarter;

(iii) If a new assessment is due for a resident or a new assessment is completed and transmitted to the department, the end date of the previous assessment shall be the earlier of either the day before the assessment is due or the day before the assessment is completed by the nursing facility.

(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 threshold of ninety percent, as described and calculated in this subsection, shall be used to determine the case mix index each quarter. The threshold shall also be used to determine which facilities' costs per case mix unit are included in determining the

ceiling, floor, and price. If the facility does not meet the ninety percent threshold, the department may use an alternate case mix index to determine the facility average and medicaid average case mix indexes for the quarter. The threshold is a count of unique minimum data set assessments, and it shall include resident assessment instrument tracking forms for residents discharged prior to completing an initial assessment. The threshold is calculated by dividing ((~~the~~)) a facility's count of ((~~unique minimum data set assessments~~)) residents being assessed by the average census for ((~~each~~)) the facility. A daily census shall be reported by each nursing facility as it transmits assessment data to the department. The department shall compute a quarterly average census based on the daily census. If no census has been reported by a facility during a specified quarter, then the department shall use the facility's licensed beds as the denominator in computing the threshold.

(7)(a) Although the facility average and the medicaid average case mix indexes shall both be calculated quarterly, the facility average case mix index will be used only every three years 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. A facility's medicaid average case mix index shall be used to update a nursing facility's direct care component rate quarterly.

(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.

(i) For October 1, 1998, direct care component rates, the department shall use an average of facility average case mix indexes from the four calendar quarters of 1997.

(ii) For July 1, 2001, direct care component rates, the department shall use an average of facility average case mix indexes from the four calendar quarters of 1999.

(c) The medicaid average case mix index used to update or recalibrate a nursing facility's direct care component rate quarterly shall be from the calendar quarter commencing six months prior to the effective date of the quarterly rate. For example, October 1, 1998, through December 31, 1998, direct care component rates shall utilize case mix averages from the April 1, 1998, through June 30, 1998, calendar quarter, and so forth.

Sec. 8. RCW 74.46.506 and 1999 c 353 s 5 and 1999 c 181 s 1 are each reenacted and 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~~)) ninety percent; that is, the greater of actual or imputed occupancy at ((~~eighty-five~~)) ninety 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, provided, that for the purposes of establishing corridors under this subsection for July 1, 2001, and following rate setting, the medians determined for the metropolitan and nonmetropolitan peer groups shall each be increased by 3.9 percent;

(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 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.

(7) Payments resulting from increases in direct care component rates, granted under authority of RCW 74.46.508(1) for a facility's exceptional care residents, shall be offset against the facility's examined, allowable direct care costs, for each report year or partial period such increases are paid. Such reductions in allowable direct care costs shall be for rate setting, settlement, and other purposes deemed appropriate by the department.

Sec. 9. RCW 74.46.511 and 1999 c 353 s 6 and 1999 c 181 s 3 are each reenacted and 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~~)) ninety 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.

(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 RCW 74.46.508(2).

Sec. 10. RCW 74.46.515 and 1999 c 353 s 7 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).

(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 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:

(i) The facility's per resident day adjusted support services costs from the applicable cost report period, using the greater of adjusted

resident days from the applicable report period or imputed occupancy at ninety percent of the facility's licensed beds; or

(ii) 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).

(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. 11. RCW 74.46.521 and 1999 c 353 s 8 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, financing allowance, and variable return.

(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).

(3) To determine each facility's operations component rate allocation 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:

(i) The facility's per resident day adjusted operations costs from the applicable cost report period, utilizing the greater of adjusted resident days from the applicable report period or imputed occupancy at ninety percent of the facility's licensed beds; or

(ii) The adjusted median per resident day general operations cost for that facility's peer group, either metropolitan statistical area or nonmetropolitan statistical area; and

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

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

Sec. 12. RCW 74.46.711 and 1995 1st sp.s. c 18 s 69 are each amended to read as follows:

Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within ((~~forty-five~~)) thirty days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate; but in the case of a resident who received long-term care services paid in whole or in part by the department, the funds and accounting shall be sent to the state of Washington, department of social and health services, office of financial recovery. The department shall establish a release procedure for use for burial expenses.

NEW SECTION. **Sec. 13.** A new section is added to chapter 74.46 RCW to read as follows:

(1) The methodologies for funding the medicaid share of the costs of nursing facility new construction, renovation, or other capital improvement projects, shall continue as provided by this chapter and department rule, however, effective July 1, 2001, projects eligible for this funding shall not exceed a total dollar limit to be established by the legislature.

(2) The department is authorized to adopt rules to administer the capital funding limit in a way that ensures:

(a) All capital improvement projects receive prior approval upon application for funding submitted to the department prior to a deadline for each state fiscal year, to be established by the department; and

(b) Projects approved for funding receive complete funding of the medicaid share of applicable costs, and those that are not approved receive no funding prior to approval.

(3) Nothing in this section is intended to alter the responsibilities or functions of the department of health in administering the certificate of need program or the construction review of health care facility projects, pursuant to chapter 70.38 RCW,

however, the department of health is authorized to consider medicaid funding approval or lack of approval in reviewing nursing facility new construction, renovation, and other capital improvement projects.

NEW SECTION. **Sec. 14.** The department of social and health services shall study and develop recommendations exploring alternate ways of paying for and providing care services to the state's needy nursing facility residents receiving assistance under the Title XIX medicaid program. The department of social and health services shall report its findings and recommendations to the legislature on or before September 1, 2002.

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

(1) RCW 74.46.280 (Management fees, agreements--Limitation on scope of services) and 1998 c 322 s 15, 1993 sp.s. c 13 s 4, & 1980 c 177 s 28; and

(2) RCW 74.46.908 (Repealer) and 1999 c 353 s 17.

NEW SECTION. **Sec. 16.** (1) Sections 1 through 14 of this act are necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and take effect July 1, 2001.

(2) Section 15 of 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 June 29, 2001.

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