
HOUSE BILL 1571

State of Washington

59th Legislature

2005 Regular Session

By Representatives Fromhold, Schual-Berke, Morrell, Linville, Moeller and Kenney

Read first time 01/28/2005. Referred to Committee on Appropriations.

1 AN ACT Relating to revising the nursing facility payment system;
2 amending RCW 74.46.431, 74.46.433, 74.46.496, 74.46.501, 74.46.506,
3 74.46.511, 74.46.515, and 74.46.521; adding a new section to chapter
4 74.46 RCW; providing an effective date; providing an expiration date;
5 and declaring an emergency.

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

7 **Sec. 1.** RCW 74.46.431 and 2004 c 276 s 913 are each amended to
8 read as follows:

9 (1) Effective July 1, 1999, nursing facility medicaid payment rate
10 allocations shall be facility-specific and shall have seven components:
11 Direct care, therapy care, support services, operations, property,
12 financing allowance, and variable return. Effective July 1, 2005, and
13 expiring June 30, 2007, there shall be an additional facility-specific
14 rate component: Insurance. The department shall establish and adjust
15 each of these components, as provided in this section and elsewhere in
16 this chapter, for each medicaid nursing facility in this state.

17 (2) All component rate allocations for essential community
18 providers as defined in this chapter shall be based upon a minimum
19 facility occupancy of eighty-five percent of licensed beds, regardless

1 of how many beds are set up or in use. For all facilities other than
2 essential community providers, effective July 1, 2001, component rate
3 allocations in direct care, therapy care, support services, variable
4 return, operations, property, and financing allowance shall continue to
5 be based upon a minimum facility occupancy of eighty-five percent of
6 licensed beds. For all facilities other than essential community
7 providers, effective July 1, 2002, the component rate allocations in
8 operations, property, and financing allowance shall be based upon a
9 minimum facility occupancy of ninety percent of licensed beds,
10 regardless of how many beds are set up or in use. Effective July 1,
11 2005, a minimum occupancy factor shall not be applied to the direct
12 care rate component, or the insurance rate component, for any facility.

13 (3) Information and data sources used in determining medicaid
14 payment rate allocations, including formulas, procedures, cost report
15 periods, resident assessment instrument formats, resident assessment
16 methodologies, and resident classification and case mix weighting
17 methodologies, may be substituted or altered from time to time as
18 determined by the department.

19 (4)(a) Direct care component rate allocations shall be established
20 using adjusted cost report data covering at least six months. Adjusted
21 cost report data from 1996 will be used for October 1, 1998, through
22 June 30, 2001, direct care component rate allocations; adjusted cost
23 report data from 1999 will be used for July 1, 2001, through June 30,
24 2005, direct care component rate allocations. Adjusted cost report
25 data from 2003 will be used for July 1, 2005, through June 30, 2007,
26 direct care component rate allocations. Effective July 1, 2007, and
27 thereafter for each odd year beginning on July 1st, direct care
28 component rate allocations shall be cost rebased and established using
29 the adjusted cost report data from the year, two years immediately
30 preceding the rate rebase period, so that: Adjusted cost report data
31 from 2005 is used for July 1, 2007, through June 30, 2009, direct care
32 component rate allocations; adjusted cost report data from 2007 is used
33 for July 1, 2009, through June 30, 2011, direct care component rate
34 allocations; and so forth.

35 (b) Direct care component rate allocations based on 1996 cost
36 report data shall be adjusted annually for economic trends and
37 conditions by a factor or factors defined in the biennial
38 appropriations act. A different economic trends and conditions

1 adjustment factor or factors may be defined in the biennial
2 appropriations act for facilities whose direct care component rate is
3 set equal to their adjusted June 30, 1998, rate, as provided in RCW
4 74.46.506(5)(i).

5 (c) Direct care component rate allocations based on 1999 cost
6 report data shall be adjusted annually for economic trends and
7 conditions by a factor or factors defined in the biennial
8 appropriations act. A different economic trends and conditions
9 adjustment factor or factors may be defined in the biennial
10 appropriations act for facilities whose direct care component rate is
11 set equal to their adjusted June 30, 1998, rate, as provided in RCW
12 74.46.506(5)(i).

13 (d) Beginning on July 1, 2005, direct care component rate
14 allocations established upon 2003 cost report data, and direct care
15 component rate allocations established upon cost report data used in
16 subsequent July 1st odd-year periods, shall be adjusted for economic
17 trends and conditions by a factor or factors defined in the biennial
18 appropriations act.

19 (e) Beginning on the effective date of this act, the direct care
20 component rate allocations, established as of July 1st in each even-
21 numbered year, beginning with July 1, 2006, shall be adjusted for
22 economic trends and conditions by a factor or factors defined in the
23 biennial appropriations act.

24 (5)(a) Therapy care component rate allocations shall be established
25 using adjusted cost report data covering at least six months. Adjusted
26 cost report data from 1996 will be used for October 1, 1998, through
27 June 30, 2001, therapy care component rate allocations; adjusted cost
28 report data from 1999 will be used for July 1, 2001, through June 30,
29 ~~((2005))~~ 2007, therapy care component rate allocations. Effective July
30 1, 2007, and thereafter for each odd year beginning on July 1st,
31 therapy care component rate allocations shall be cost rebased and
32 established using the adjusted cost report data from the year, two
33 years immediately preceding the rate rebase period, so that: Adjusted
34 cost report data from 2005 is used for July 1, 2007, through June 30,
35 2009, therapy care component rate allocations; adjusted cost report
36 data from 2007 is used for July 1, 2009, through June 30, 2011, therapy
37 care component rate allocations; and so forth.

1 (b) Therapy care component rate allocations shall be adjusted
2 annually for economic trends and conditions by a factor or factors
3 defined in the biennial appropriations act until June 30, 2005.

4 (c) Effective July 1, 2005, through June 30, 2007, the therapy care
5 component rate allocation shall be adjusted for economic trends and
6 conditions by a factor or factors defined in the biennial
7 appropriations act.

8 (d) Beginning on July 1, 2007, therapy care component rate
9 allocations established upon 2005 cost report data, and therapy care
10 component rate allocations established upon cost report data used in
11 subsequent July 1st odd-year periods, shall be adjusted for economic
12 trends and conditions by a factor or factors defined in the biennial
13 appropriations act.

14 (e) Beginning on the effective date of this act, the therapy care
15 component rate allocations, established as of July 1st in each even-
16 numbered year, beginning with July 1, 2008, shall be adjusted for
17 economic trends and conditions by a factor or factors defined in the
18 biennial appropriations act.

19 (6)(a) Support services component rate allocations shall be
20 established using adjusted cost report data covering at least six
21 months. Adjusted cost report data from 1996 shall be used for October
22 1, 1998, through June 30, 2001, support services component rate
23 allocations; adjusted cost report data from 1999 shall be used for July
24 1, 2001, through June 30, (~~2005~~) 2007, support services component
25 rate allocations. Effective July 1, 2007, and thereafter for each odd
26 year beginning on July 1st, support services component rate allocations
27 shall be cost rebased and established using the adjusted cost report
28 data from the year, two years immediately preceding the rate rebase
29 period, so that: Adjusted cost report data from 2005 is used for July
30 1, 2007, through June 30, 2009, support services component rate
31 allocations; adjusted cost report data from 2007 is used for July 1,
32 2009, through June 30, 2011, support services component rate
33 allocations; and so forth.

34 (b) Support services component rate allocations shall be adjusted
35 annually for economic trends and conditions by a factor or factors
36 defined in the biennial appropriations act until June 30, 2005.

37 (c) Effective July 1, 2005, through June 30, 2007, the support

1 services component rate allocation shall be adjusted for economic
2 trends and conditions by a factor or factors defined in the biennial
3 appropriations act.

4 (d) Beginning on July 1, 2007, support services component rate
5 allocations established upon 2005 cost report data, and support
6 services component rate allocations established upon cost report data
7 used in subsequent July 1st odd-year periods, shall be adjusted for
8 economic trends and conditions by a factor or factors defined in the
9 biennial appropriations act.

10 (e) Beginning on the effective date of this act, the support
11 services component rate allocations, established as of July 1st in each
12 even-numbered year, beginning with July 1, 2008, shall be adjusted for
13 economic trends and conditions by a factor or factors defined in the
14 biennial appropriations act.

15 (7)(a) Operations component rate allocations shall be established
16 using adjusted cost report data covering at least six months. Adjusted
17 cost report data from 1996 shall be used for October 1, 1998, through
18 June 30, 2001, operations component rate allocations; adjusted cost
19 report data from 1999 shall be used for July 1, 2001, through June 30,
20 ~~((2005))~~ 2007, operations component rate allocations. Effective July
21 1, 2007, and thereafter for each odd year beginning on July 1st,
22 operations component rate allocations shall be cost rebased and
23 established using the adjusted cost report data from the year, two
24 years immediately preceding the rate rebase period, so that: Adjusted
25 cost report data from 2005 is used for July 1, 2007, through June 30,
26 2009, operations component rate allocations; adjusted cost report data
27 from 2007 is used for July 1, 2009, through June 30, 2011, operations
28 component rate allocations; and so forth.

29 (b) Operations component rate allocations shall be adjusted
30 annually for economic trends and conditions by a factor or factors
31 defined in the biennial appropriations act until June 30, 2005.

32 (c) Effective July 1, 2005, through June 30, 2007, the operations
33 component rate allocation shall be adjusted for economic trends and
34 conditions by a factor or factors defined in the biennial
35 appropriations act.

36 (d) Beginning on July 1, 2007, operations component rate
37 allocations established upon 2005 cost report data, and operations
38 component rate allocations established upon cost report data used in

1 subsequent July 1st odd-year periods, shall be adjusted for economic
2 trends and conditions by a factor or factors defined in the biennial
3 appropriations act.

4 (e) Beginning on the effective date of this act, the operations
5 component rate allocations, established as of July 1st in each even-
6 numbered year, beginning with July 1, 2008, shall be adjusted for
7 economic trends and conditions by a factor or factors defined in the
8 biennial appropriations act.

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

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

19 (10) Medicaid contractors shall pay to all facility staff a minimum
20 wage of the greater of the state minimum wage or the federal minimum
21 wage.

22 (11) The department shall establish in rule procedures, principles,
23 and conditions for determining component rate allocations for
24 facilities in circumstances not directly addressed by this chapter,
25 including but not limited to: The need to prorate inflation for
26 partial-period cost report data, newly constructed facilities, existing
27 facilities entering the medicaid program for the first time or after a
28 period of absence from the program, existing facilities with expanded
29 new bed capacity, existing medicaid facilities following a change of
30 ownership of the nursing facility business, facilities banking beds or
31 converting beds back into service, facilities temporarily reducing the
32 number of set-up beds during a remodel, facilities having less than six
33 months of either resident assessment, cost report data, or both, under
34 the current contractor prior to rate setting, and other circumstances.

35 (12) The department shall establish in rule procedures, principles,
36 and conditions, including necessary threshold costs, for adjusting
37 rates to reflect capital improvements or new requirements imposed by

1 the department or the federal government. Any such rate adjustments
2 are subject to the provisions of RCW 74.46.421.

3 (13) Effective July 1, 2001, medicaid rates shall continue to be
4 revised downward in all components, in accordance with department
5 rules, for facilities converting banked beds to active service under
6 chapter 70.38 RCW, by using the facility's increased licensed bed
7 capacity to recalculate minimum occupancy for rate setting. However,
8 for facilities other than essential community providers which bank beds
9 under chapter 70.38 RCW, after May 25, 2001, medicaid rates shall be
10 revised upward, in accordance with department rules, in direct care,
11 therapy care, support services, and variable return components only, by
12 using the facility's decreased licensed bed capacity to recalculate
13 minimum occupancy for rate setting, but no upward revision shall be
14 made to operations, property, or financing allowance component rates.
15 The direct care rate component allocation shall be adjusted, without
16 using the minimum occupancy threshold, for facilities that convert
17 banked beds to active service, under chapter 70.38 RCW, on or after
18 July 1, 2005.

19 (14) Facilities obtaining a certificate of need or a certificate of
20 need exemption under chapter 70.38 RCW after June 30, 2001, must have
21 a certificate of capital authorization in order for (a) the
22 depreciation resulting from the capitalized addition to be included in
23 calculation of the facility's property component rate allocation; and
24 (b) the net invested funds associated with the capitalized addition to
25 be included in calculation of the facility's financing allowance rate
26 allocation.

27 **Sec. 2.** RCW 74.46.433 and 2001 1st sp.s. c 8 s 6 are each amended
28 to read as follows:

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

32 (a) The variable return array and percentage shall be assigned
33 whenever rebasing of noncapital rate allocations is scheduled under RCW
34 (~~(46.46.431 [74.46.431])~~) 74.46.431 (4), (5), (6), and (7).

35 (b) To calculate the array of facilities for the July 1, 2001, rate
36 setting, the department, without using peer groups, shall first rank
37 all facilities in numerical order from highest to lowest according to

1 each facility's examined and documented, but unlidged, combined direct
2 care, therapy care, support services, and operations per resident day
3 cost from the 1999 cost report period. However, before being combined
4 with other per resident day costs and ranked, a facility's direct care
5 cost per resident day shall be adjusted to reflect its facility average
6 case mix index, to be averaged from the four calendar quarters of 1999,
7 weighted by the facility's resident days from each quarter, under RCW
8 74.46.501(7)(b)(ii). The array shall then be divided into four
9 quartiles, each containing, as nearly as possible, an equal number of
10 facilities, and four percent shall be assigned to facilities in the
11 lowest quartile, three percent to facilities in the next lowest
12 quartile, two percent to facilities in the next highest quartile, and
13 one percent to facilities in the highest quartile.

14 (c) To calculate the array of facilities for July 1, 2005, and each
15 subsequent July 1st rate setting occurring in an odd-numbered year, the
16 department, without using peer groups, shall first rank all facilities
17 in numerical order from highest to lowest according to each facility's
18 examined and documented, but unlidged, combined direct care, therapy
19 care, support services, and operations per resident day cost from the
20 calendar year cost report period specified in RCW 74.46.431. However,
21 before being combined with other per resident day costs and ranked, a
22 facility's direct care cost per resident day shall be adjusted to
23 reflect its facility average case mix index, to be averaged from the
24 four calendar quarters of the cost report period used to rebase each
25 odd-numbered year's July 1st component rate allocations, weighted by
26 the facility's resident days from each quarter under RCW
27 74.46.501(7)(b)(iii). The array shall then be divided into four
28 quartiles, each containing, as nearly as possible, an equal number of
29 facilities, and four percent shall be assigned to facilities in the
30 lowest quartile, three percent to facilities in the next lowest
31 quartile, two percent to facilities in the next highest quartile, and
32 one percent to facilities in the highest quartile. The department
33 shall(, ~~subject to (d) of this subsection,~~) compute the variable
34 return allowance by multiplying a facility's assigned percentage by the
35 sum of the facility's direct care, therapy care, support services, and
36 operations component rates determined in accordance with this chapter
37 and rules adopted by the department.

1 ~~((d) Effective July 1, 2001, if a facility's examined and~~
2 ~~documented direct care cost per resident day for the preceding report~~
3 ~~year is lower than its average direct care component rate weighted by~~
4 ~~medicaid resident days for the same year, the facility's direct care~~
5 ~~cost shall be substituted for its July 1, 2001, direct care component~~
6 ~~rate, and its variable return component rate shall be determined or~~
7 ~~adjusted each July 1st by multiplying the facility's assigned~~
8 ~~percentage by the sum of the facility's July 1, 2001, therapy care,~~
9 ~~support services, and operations component rates, and its direct care~~
10 ~~cost per resident day for the preceding year.))~~

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

14 **Sec. 3.** RCW 74.46.496 and 1998 c 322 s 23 are each amended to read
15 as follows:

16 (1) Each case mix classification group shall be assigned a case mix
17 weight. The case mix weight for each resident of a nursing facility
18 for each calendar quarter shall be based on data from resident
19 assessment instruments completed for the resident and weighted by the
20 number of days the resident was in each case mix classification group.
21 Days shall be counted as provided in this section.

22 (2) The case mix weights shall be based on the average minutes per
23 registered nurse, licensed practical nurse, and certified nurse aide,
24 for each case mix group, and using the health care financing
25 administration of the United States department of health and human
26 services 1995 nursing facility staff time measurement study stemming
27 from its multistate nursing home case mix and quality demonstration
28 project. Those minutes shall be weighted by statewide ratios of
29 registered nurse to certified nurse aide, and licensed practical nurse
30 to certified nurse aide, wages, including salaries and benefits, which
31 shall be based on 1995 cost report data for this state.

32 (3) The case mix weights shall be determined as follows:

33 (a) Set the certified nurse aide wage weight at 1.000 and calculate
34 wage weights for registered nurse and licensed practical nurse average
35 wages by dividing the certified nurse aide average wage into the
36 registered nurse average wage and licensed practical nurse average
37 wage;

1 (b) Calculate the total weighted minutes for each case mix group in
2 the resource utilization group III classification system by multiplying
3 the wage weight for each worker classification by the average number of
4 minutes that classification of worker spends caring for a resident in
5 that resource utilization group III classification group, and summing
6 the products;

7 (c) Assign a case mix weight of 1.000 to the resource utilization
8 group III classification group with the lowest total weighted minutes
9 and calculate case mix weights by dividing the lowest group's total
10 weighted minutes into each group's total weighted minutes and rounding
11 weight calculations to the third decimal place.

12 (4) The case mix weights in this state may be revised if the health
13 care financing administration updates its nursing facility staff time
14 measurement studies. The case mix weights shall be revised, but only
15 when direct care component rates are cost-rebased as provided in
16 subsection (5) of this section, to be effective on the July 1st
17 effective date of each cost-rebased direct care component rate.
18 However, the department may revise case mix weights more frequently if,
19 and only if, significant variances in wage ratios occur among direct
20 care staff in the different caregiver classifications identified in
21 this section.

22 (5) Case mix weights shall be revised when direct care component
23 rates are cost-rebased (~~((every three years))~~) as provided in RCW
24 74.46.431(4)(a).

25 **Sec. 4.** RCW 74.46.501 and 2001 1st sp.s. c 8 s 9 are each amended
26 to read as follows:

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

32 (2)(a) In calculating a facility's two average case mix indexes for
33 each quarter, the department shall include all residents or medicaid
34 residents, as applicable, who were physically in the facility during
35 the quarter in question (January 1st through March 31st, April 1st
36 through June 30th, July 1st through September 30th, or October 1st
37 through December 31st).

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

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

9 (4)(a) In determining the number of days a resident is classified
10 into a particular case mix group, the department shall determine a
11 start date for calculating case mix grouping periods as follows:

12 (i) If a resident's initial assessment for a first stay or a return
13 stay in the nursing facility is timely completed and transmitted to the
14 department by the cutoff date under state and federal requirements and
15 as described in subsection (5) of this section, the start date shall be
16 the later of either the first day of the quarter or the resident's
17 facility admission or readmission date;

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

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

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

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

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

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

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

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

12 (6) A threshold of ninety percent, as described and calculated in
13 this subsection, shall be used to determine the case mix index each
14 quarter. The threshold shall also be used to determine which
15 facilities' costs per case mix unit are included in determining the
16 ceiling, floor, and price. For direct care component rate allocations
17 established on and after July 1, 2005, the threshold of ninety percent
18 shall be used to determine the case mix index each quarter and to
19 determine which facilities' costs per case mix unit are included in
20 determining the ceiling and price. If the facility does not meet the
21 ninety percent threshold, the department may use an alternate case mix
22 index to determine the facility average and medicaid average case mix
23 indexes for the quarter. The threshold is a count of unique minimum
24 data set assessments, and it shall include resident assessment
25 instrument tracking forms for residents discharged prior to completing
26 an initial assessment. The threshold is calculated by dividing a
27 facility's count of residents being assessed by the average census for
28 the facility. A daily census shall be reported by each nursing
29 facility as it transmits assessment data to the department. The
30 department shall compute a quarterly average census based on the daily
31 census. If no census has been reported by a facility during a
32 specified quarter, then the department shall use the facility's
33 licensed beds as the denominator in computing the threshold.

34 (7)(a) Although the facility average and the medicaid average case
35 mix indexes shall both be calculated quarterly, the facility average
36 case mix index will be used (~~only every three years~~) throughout the
37 applicable cost-rebasing period in combination with cost report data as
38 specified by RCW 74.46.431 and 74.46.506, to establish a facility's

1 allowable cost per case mix unit. A facility's medicaid average case
2 mix index shall be used to update a nursing facility's direct care
3 component rate quarterly.

4 (b) The facility average case mix index used to establish each
5 nursing facility's direct care component rate shall be based on an
6 average of calendar quarters of the facility's average case mix
7 indexes.

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

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

14 (iii) Beginning on July 1, 2005, and for each subsequent July 1st
15 occurring in an odd-numbered year, when establishing the direct care
16 component rates, the department shall use an average of facility case
17 mix indexes from the four calendar quarters occurring during the cost
18 report period used to rebase the direct care component rate allocations
19 as specified in RCW 74.46.431.

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

27 **Sec. 5.** RCW 74.46.506 and 2001 1st sp.s. c 8 s 10 are each amended
28 to read as follows:

29 (1) The direct care component rate allocation corresponds to the
30 provision of nursing care for one resident of a nursing facility for
31 one day, including direct care supplies. Therapy services and
32 supplies, which correspond to the therapy care component rate, shall be
33 excluded. The direct care component rate includes elements of case mix
34 determined consistent with the principles of this section and other
35 applicable provisions of this chapter.

36 (2) Beginning October 1, 1998, the department shall determine and
37 update quarterly for each nursing facility serving medicaid residents

1 a facility-specific per-resident day direct care component rate
2 allocation, to be effective on the first day of each calendar quarter.
3 In determining direct care component rates the department shall
4 utilize, as specified in this section, minimum data set resident
5 assessment data for each resident of the facility, as transmitted to,
6 and if necessary corrected by, the department in the resident
7 assessment instrument format approved by federal authorities for use in
8 this state.

9 (3) The department may question the accuracy of assessment data for
10 any resident and utilize corrected or substitute information, however
11 derived, in determining direct care component rates. The department is
12 authorized to impose civil fines and to take adverse rate actions
13 against a contractor, as specified by the department in rule, in order
14 to obtain compliance with resident assessment and data transmission
15 requirements and to ensure accuracy.

16 (4) Cost report data used in setting direct care component rate
17 allocations shall be 1996 and 1999((7)) for rate periods ending June
18 30, 2005, and shall be the immediately two years preceding cost report
19 data for direct care component rate allocations set beginning July 1,
20 2005, and each subsequent July 1st, occurring in each subsequent odd-
21 numbered year, as specified in RCW 74.46.431(4)(a).

22 (5) Beginning October 1, 1998, the department shall rebase each
23 nursing facility's direct care component rate allocation as described
24 in RCW 74.46.431, adjust its direct care component rate allocation for
25 economic trends and conditions as described in RCW 74.46.431, and
26 update its medicaid average case mix index, consistent with the
27 following:

28 (a) Reduce total direct care costs reported by each nursing
29 facility for the applicable cost report period specified in RCW
30 74.46.431(4)(a) to reflect any department adjustments, and to eliminate
31 reported resident therapy costs and adjustments, in order to derive the
32 facility's total allowable direct care cost;

33 (b) Divide each facility's total allowable direct care cost by its
34 adjusted resident days for the same report period, increased if
35 necessary to a minimum occupancy of eighty-five percent; that is, the
36 greater of actual or imputed occupancy at eighty-five percent of
37 licensed beds, to derive the facility's allowable direct care cost per
38 resident day. However, effective July 1, 2005, forward, and for all

1 future rate setting, each facility's allowable direct care costs shall
2 be divided by its adjusted resident days without application of a
3 minimum occupancy threshold;

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

8 (d) Divide each facility's adjusted allowable direct care cost per
9 resident day by the facility average case mix index for the applicable
10 quarters specified by RCW 74.46.501(7)(b) to derive the facility's
11 allowable direct care cost per case mix unit;

12 (e) Effective for July 1, 2001, rate setting, divide nursing
13 facilities into at least two and, if applicable, three peer groups:
14 Those located in nonurban counties; those located in high labor-cost
15 counties, if any; and those located in other urban counties;

16 (f) Array separately the allowable direct care cost per case mix
17 unit for all facilities in nonurban counties; for all facilities in
18 high labor-cost counties, if applicable; and for all facilities in
19 other urban counties, and determine the median allowable direct care
20 cost per case mix unit for each peer group;

21 (g) Except as provided in (i) of this subsection, from October 1,
22 1998, through June 30, 2000, determine each facility's quarterly direct
23 care component rate as follows:

24 (i) Any facility whose allowable cost per case mix unit is less
25 than eighty-five percent of the facility's peer group median
26 established under (f) of this subsection shall be assigned a cost per
27 case mix unit equal to eighty-five percent of the facility's peer group
28 median, and shall have a direct care component rate allocation equal to
29 the facility's assigned cost per case mix unit multiplied by that
30 facility's medicaid average case mix index from the applicable quarter
31 specified in RCW 74.46.501(7)(c);

32 (ii) Any facility whose allowable cost per case mix unit is greater
33 than one hundred fifteen percent of the peer group median established
34 under (f) of this subsection shall be assigned a cost per case mix unit
35 equal to one hundred fifteen percent of the peer group median, and
36 shall have a direct care component rate allocation equal to the
37 facility's assigned cost per case mix unit multiplied by that

1 facility's medicaid average case mix index from the applicable quarter
2 specified in RCW 74.46.501(7)(c);

3 (iii) Any facility whose allowable cost per case mix unit is
4 between eighty-five and one hundred fifteen percent of the peer group
5 median established under (f) of this subsection shall have a direct
6 care component rate allocation equal to the facility's allowable cost
7 per case mix unit multiplied by that facility's medicaid average case
8 mix index from the applicable quarter specified in RCW 74.46.501(7)(c);

9 (h) Except as provided in (i) of this subsection, from July 1,
10 2000, (~~(forward, and for all future rate setting)~~) through June 30,
11 2005, determine each facility's quarterly direct care component rate as
12 follows:

13 (i) Any facility whose allowable cost per case mix unit is less
14 than ninety percent of the facility's peer group median established
15 under (f) of this subsection shall be assigned a cost per case mix unit
16 equal to ninety percent of the facility's peer group median, and shall
17 have a direct care component rate allocation equal to the facility's
18 assigned cost per case mix unit multiplied by that facility's medicaid
19 average case mix index from the applicable quarter specified in RCW
20 74.46.501(7)(c);

21 (ii) Any facility whose allowable cost per case mix unit is greater
22 than one hundred ten percent of the peer group median established under
23 (f) of this subsection shall be assigned a cost per case mix unit equal
24 to one hundred ten percent of the peer group median, and shall have a
25 direct care component rate allocation equal to the facility's assigned
26 cost per case mix unit multiplied by that facility's medicaid average
27 case mix index from the applicable quarter specified in RCW
28 74.46.501(7)(c);

29 (iii) Any facility whose allowable cost per case mix unit is
30 between ninety and one hundred ten percent of the peer group median
31 established under (f) of this subsection shall have a direct care
32 component rate allocation equal to the facility's allowable cost per
33 case mix unit multiplied by that facility's medicaid average case mix
34 index from the applicable quarter specified in RCW 74.46.501(7)(c);

35 (i)(i) Between October 1, 1998, and June 30, 2000, the department
36 shall compare each facility's direct care component rate allocation
37 calculated under (g) of this subsection with the facility's nursing
38 services component rate in effect on September 30, 1998, less therapy

1 costs, plus any exceptional care offsets as reported on the cost
2 report, adjusted for economic trends and conditions as provided in RCW
3 74.46.431. A facility shall receive the higher of the two rates.

4 (ii) Between July 1, 2000, and June 30, 2002, the department shall
5 compare each facility's direct care component rate allocation
6 calculated under (h) of this subsection with the facility's direct care
7 component rate in effect on June 30, 2000. A facility shall receive
8 the higher of the two rates. Between July 1, 2001, and June 30, 2002,
9 if during any quarter a facility whose rate paid under (h) of this
10 subsection is greater than either the direct care rate in effect on
11 June 30, 2000, or than that facility's allowable direct care cost per
12 case mix unit calculated in (d) of this subsection multiplied by that
13 facility's medicaid average case mix index from the applicable quarter
14 specified in RCW 74.46.501(7)(c), the facility shall be paid in that
15 and each subsequent quarter pursuant to (h) of this subsection and
16 shall not be entitled to the greater of the two rates.

17 (iii) Effective July 1, 2002, through June 30, 2005, all direct
18 care component rate allocations shall be as determined under (h) of
19 this subsection;

20 (j) Effective July 1, 2005, forward, and for all future rate
21 setting, determine each facility's quarterly direct care component rate
22 as follows:

23 (i) Any facility whose allowable cost per case mix unit is greater
24 than one hundred twenty-five percent of the peer group median
25 established under (f) of this subsection shall be assigned a cost per
26 case mix unit equal to one hundred twenty-five percent of the peer
27 group median, and shall have a direct care component rate allocation
28 equal to the facility's assigned cost per case mix unit multiplied by
29 that facility's medicaid average case mix index from the applicable
30 quarter specified in RCW 74.46.501(7)(c);

31 (ii) Any facility whose allowable cost per case mix unit is less
32 than one hundred twenty-five percent of the peer group median
33 established under (f) of this subsection shall have a direct care
34 component rate allocation equal to the facility's allowable cost per
35 case mix unit multiplied by that facility's medicaid average case mix
36 index from the applicable quarter specified in RCW 74.46.501(7)(c).

37 (6) The direct care component rate allocations calculated in

1 accordance with this section shall be adjusted to the extent necessary
2 to comply with RCW 74.46.421.

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

10 **Sec. 6.** RCW 74.46.511 and 2001 1st sp.s. c 8 s 11 are each amended
11 to read as follows:

12 (1) The therapy care component rate allocation corresponds to the
13 provision of medicaid one-on-one therapy provided by a qualified
14 therapist as defined in this chapter, including therapy supplies and
15 therapy consultation, for one day for one medicaid resident of a
16 nursing facility. The therapy care component rate allocation for
17 October 1, 1998, through June 30, 2001, shall be based on adjusted
18 therapy costs and days from calendar year 1996. The therapy component
19 rate allocation for July 1, 2001, through June 30, (~~2004~~) 2007, shall
20 be based on adjusted therapy costs and days from calendar year 1999.
21 For July 1, 2007, and each subsequent July 1st occurring in an odd-
22 numbered year, therapy care component rate allocations shall be based
23 on adjusted therapy costs and days as described in RCW 74.46.431(5)(a).
24 The therapy care component rate shall be adjusted for economic trends
25 and conditions as specified in RCW 74.46.431(5) (b), (c), (d), and (e),
26 and shall be determined in accordance with this section.

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

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

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

36 (c) Therapy consulting expenses for all residents.

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

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

7 (a) Those facilities located within urban counties; and

8 (b) Those located within nonurban counties.

9 The department shall array the facilities in each peer group from
10 highest to lowest based on their total cost per unit of therapy for
11 each therapy type. The department shall determine the median total
12 cost per unit of therapy for each therapy type and add ten percent of
13 median total cost per unit of therapy. The cost per unit of therapy
14 for each therapy type at a nursing facility shall be the lesser of its
15 cost per unit of therapy for each therapy type or the median total cost
16 per unit plus ten percent for each therapy type for its peer group.

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

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

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

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

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

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

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

9 (6) The therapy care component rate allocations calculated in
10 accordance with this section shall be adjusted to the extent necessary
11 to comply with RCW 74.46.421.

12 (7) The therapy care component rate shall be suspended for medicaid
13 residents in qualified nursing facilities designated by the department
14 who are receiving therapy paid by the department outside the facility
15 daily rate under RCW 74.46.508(2).

16 **Sec. 7.** RCW 74.46.515 and 2001 1st sp.s. c 8 s 12 are each amended
17 to read as follows:

18 (1) The support services component rate allocation corresponds to
19 the provision of food, food preparation, dietary, housekeeping, and
20 laundry services for one resident for one day.

21 (2) Beginning October 1, 1998, the department shall determine each
22 medicaid nursing facility's support services component rate allocation
23 using cost report data specified by RCW 74.46.431(6)(a).

24 (3) To determine each facility's support services component rate
25 allocation, the department shall:

26 (a) Array facilities' adjusted support services costs per adjusted
27 resident day for each facility from facilities' cost reports from the
28 applicable report year, for facilities located within urban counties,
29 and for those located within nonurban counties and determine the median
30 adjusted cost for each peer group;

31 (b) Set each facility's support services component rate at the
32 lower of the facility's per resident day adjusted support services
33 costs from the applicable cost report period or the adjusted median per
34 resident day support services cost for that facility's peer group,
35 either urban counties or nonurban counties, plus ten percent; and

36 (c) Adjust each facility's support services component rate for

1 economic trends and conditions as provided in RCW 74.46.431(6) (b),
2 (c), (d), and (e).

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

6 **Sec. 8.** RCW 74.46.521 and 2001 1st sp.s. c 8 s 13 are each amended
7 to read as follows:

8 (1) The operations component rate allocation corresponds to the
9 general operation of a nursing facility for one resident for one day,
10 including but not limited to management, administration, utilities,
11 office supplies, accounting and bookkeeping, minor building
12 maintenance, minor equipment repairs and replacements, and other
13 supplies and services, exclusive of direct care, therapy care, support
14 services, property, financing allowance, and variable return.

15 (2) Beginning October 1, 1998, the department shall determine each
16 medicaid nursing facility's operations component rate allocation using
17 cost report data specified by RCW 74.46.431(7)(a). Effective July 1,
18 2002, operations component rates for all facilities except essential
19 community providers shall be based upon a minimum occupancy of ninety
20 percent of licensed beds, and no operations component rate shall be
21 revised in response to beds banked on or after May 25, 2001, under
22 chapter 70.38 RCW.

23 (3) To determine each facility's operations component rate the
24 department shall:

25 (a) Array facilities' adjusted general operations costs per
26 adjusted resident day for each facility from facilities' cost reports
27 from the applicable report year, for facilities located within urban
28 counties and for those located within nonurban counties and determine
29 the median adjusted cost for each peer group;

30 (b) Set each facility's operations component rate at the lower of:

31 (i) The facility's per resident day adjusted operations costs from
32 the applicable cost report period adjusted if necessary to a minimum
33 occupancy of eighty-five percent of licensed beds before July 1, 2002,
34 and ninety percent effective July 1, 2002; or

35 (ii) The adjusted median per resident day general operations cost
36 for that facility's peer group, urban counties or nonurban counties;
37 and

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

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

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

9 (1) The insurance component rate allocation corresponds to the
10 labor and industries workers' compensation insurance and property and
11 casualty insurance premiums paid by a nursing facility.

12 (2) Beginning July 1, 2005, the department shall establish each
13 medicaid nursing facility's insurance component rate allocation by
14 determining the incremental increase in each facility's insurance costs
15 by comparing the facility's insurance related costs as reported in
16 their 1999 cost report data and their 2003 cost report data, excluding
17 that portion of the insurance costs included in the direct care
18 component. The insurance component rate allocation shall be a per
19 resident day amount using total days from the 2003 cost report.

20 (3) Beginning July 1, 2006, the department shall establish each
21 medicaid nursing facility's insurance component rate allocation by
22 determining the incremental increase in each facility's insurance costs
23 by comparing the facility's insurance related costs as reported in
24 their 1999 cost report data and their 2004 cost report data, excluding
25 that portion of the insurance costs included in the direct care
26 component. The insurance component rate allocation shall be a per
27 resident day amount using total days from the 2004 cost report.

28 (4) This section expires June 30, 2007.

29 NEW SECTION. Sec. 10. This act is necessary for the immediate
30 preservation of the public peace, health, or safety, or support of the
31 state government and its existing public institutions, and takes effect
32 July 1, 2005.

--- END ---