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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.

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

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

Sec. 1. RCW 74.46.431 and 2004 c 276 s 913 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. Effective July 1, 2005, and expiring June 30, 2007, there shall be an additional facility-specific rate component: Insurance. 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 for essential community providers as defined in this chapter shall be based upon a minimum facility occupancy of eighty-five percent of licensed beds, regardless

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

(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, 2005, direct care component rate allocations. Adjusted cost report data from 2003 will be used for July 1, 2005, through June 30, 2007, direct care component rate allocations. Effective July 1, 2007, and thereafter for each odd year beginning on July 1st, direct care component rate allocations shall be cost rebased and established using the adjusted cost report data from the year, two years immediately preceding the rate rebase period, so that: Adjusted cost report data from 2005 is used for July 1, 2007, through June 30, 2009, direct care component rate allocations; adjusted cost report data from 2007 is used for July 1, 2009, through June 30, 2011, direct care component rate allocations; and so forth.

(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)(i).

(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)(i).

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

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

(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, ((~~2005~~)) 2007, therapy care component rate allocations. Effective July 1, 2007, and thereafter for each odd year beginning on July 1st, therapy care component rate allocations shall be cost rebased and established using the adjusted cost report data from the year, two years immediately preceding the rate rebase period, so that: Adjusted cost report data from 2005 is used for July 1, 2007, through June 30, 2009, therapy care component rate allocations; adjusted cost report data from 2007 is used for July 1, 2009, through June 30, 2011, therapy care component rate allocations; and so forth.

(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 until June 30, 2005.

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

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

(e) Beginning on the effective date of this act, the therapy care component rate allocations, established as of July 1st in each even-numbered year, beginning with July 1, 2008, shall be adjusted 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, ((~~2005~~)) 2007, support services component rate allocations. Effective July 1, 2007, and thereafter for each odd year beginning on July 1st, support services component rate allocations shall be cost rebased and established using the adjusted cost report data from the year, two years immediately preceding the rate rebase period, so that: Adjusted cost report data from 2005 is used for July 1, 2007, through June 30, 2009, support services component rate allocations; adjusted cost report data from 2007 is used for July 1, 2009, through June 30, 2011, support services component rate allocations; and so forth.

(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 until June 30, 2005.

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

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

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

(e) Beginning on the effective date of this act, the support services component rate allocations, established as of July 1st in each even-numbered year, beginning with July 1, 2008, shall be adjusted 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, ((~~2005~~)) 2007, operations component rate allocations. Effective July 1, 2007, and thereafter for each odd year beginning on July 1st, operations component rate allocations shall be cost rebased and established using the adjusted cost report data from the year, two years immediately preceding the rate rebase period, so that: Adjusted cost report data from 2005 is used for July 1, 2007, through June 30, 2009, operations component rate allocations; adjusted cost report data from 2007 is used for July 1, 2009, through June 30, 2011, operations component rate allocations; and so forth.

(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 until June 30, 2005.

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

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

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

(e) Beginning on the effective date of this act, the operations component rate allocations, established as of July 1st in each even-numbered year, beginning with July 1, 2008, shall be adjusted 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 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 temporarily reducing the number of set-up beds during a remodel, 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.

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

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

Sec. 2. RCW 74.46.433 and 2001 1st sp.s. c 8 s 6 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 shall be assigned whenever rebasing of noncapital rate allocations is scheduled under RCW ((~~46.46.431 [74.46.431]~~)) 74.46.431 (4), (5), (6), and (7).

(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) To calculate the array of facilities for July 1, 2005, and each subsequent July 1st rate setting occurring in an odd-numbered year, 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 calendar year cost report period specified in RCW 74.46.431. 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 the cost report period used to rebase each odd-numbered year's July 1st component rate allocations, weighted by the facility's resident days from each quarter under RCW 74.46.501(7)(b)(iii). 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. The department shall((~~, subject to (d) of this subsection,~~)) compute the variable return allowance by multiplying a facility's assigned percentage by the sum of the facility's direct care, therapy care, support services, and operations component rates determined in accordance with this chapter and rules adopted by the department.

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

(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. 3. RCW 74.46.496 and 1998 c 322 s 23 are each amended to read as follows:

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

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

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

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

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

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

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

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

Sec. 4. RCW 74.46.501 and 2001 1st sp.s. c 8 s 9 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. For direct care component rate allocations established on and after July 1, 2005, the threshold of ninety percent shall be used to determine the case mix index each quarter and to determine which facilities' costs per case mix unit are included in determining the ceiling 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 a facility's count of residents being assessed by the average census for 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~~)) throughout the applicable cost-rebasing period 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) Except as provided in (i) 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 (i) of this subsection, from July 1, 2000, ((~~forward, and for all future rate setting~~)) through June 30, 2005, 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)(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. Between July 1, 2001, and June 30, 2002, if during any quarter a facility whose rate paid under (h) of this subsection is greater than either the direct care rate in effect on June 30, 2000, or than that facility's allowable direct care cost per case mix unit calculated in (d) of this subsection multiplied by that facility's medicaid average case mix index from the applicable quarter specified in RCW 74.46.501(7)(c), the facility shall be paid in that and each subsequent quarter pursuant to (h) of this subsection and shall not be entitled to the greater of the two rates.

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

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

(i) Any facility whose allowable cost per case mix unit is greater than one hundred twenty-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 twenty-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);

(ii) Any facility whose allowable cost per case mix unit is less than one hundred twenty-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).

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

(1) The therapy care component rate allocation corresponds to the provision of medicaid one-on-one therapy provided by a qualified therapist as defined in this chapter, including therapy supplies and therapy consultation, for one day for one medicaid resident of a nursing facility. The therapy care component rate allocation for October 1, 1998, through June 30, 2001, shall be based on adjusted therapy costs and days from calendar year 1996. The therapy component rate allocation for July 1, 2001, through June 30, ((~~2004~~)) 2007, shall be based on adjusted therapy costs and days from calendar year 1999. For July 1, 2007, and each subsequent July 1st occurring in an odd-numbered year, therapy care component rate allocations shall be based on adjusted therapy costs and days as described in RCW 74.46.431(5)(a). The therapy care component rate shall be adjusted for economic trends and conditions as specified in RCW 74.46.431(5) (b), (c), (d), and (e), 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 urban counties; and

(b) Those located within nonurban counties.

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

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

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

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

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

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

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

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

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

(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. 7. RCW 74.46.515 and 2001 1st sp.s. c 8 s 12 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)(a).

(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 urban counties, and for those located within nonurban counties and determine the median adjusted cost for each peer group;

(b) Set each facility's support services component rate at the lower of the facility's per resident day adjusted support services costs from the applicable cost report period or the adjusted median per resident day support services cost for that facility's peer group, either urban counties or nonurban counties, 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) (b), (c), (d), and (e).

(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. 8. RCW 74.46.521 and 2001 1st sp.s. c 8 s 13 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). Effective July 1, 2002, operations component rates for all facilities except essential community providers shall be based upon a minimum occupancy of ninety percent of licensed beds, and no operations component rate shall be revised in response to beds banked on or after May 25, 2001, under chapter 70.38 RCW.

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

(a) Array facilities' adjusted general operations costs per adjusted resident day for each facility from facilities' cost reports from the applicable report year, for facilities located within urban counties and for those located within nonurban counties 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 adjusted if necessary to a minimum occupancy of eighty-five percent of licensed beds before July 1, 2002, and ninety percent effective July 1, 2002; or

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

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

(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.

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

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

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

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

(4) This section expires June 30, 2007.

NEW SECTION. **Sec. 10.** 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 July 1, 2005.

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