H-5027.2

HOUSE BILL 3202

State of Washington 61st Legislature 2010 Regular Session

By Representative Cody

Read first time 03/01/10. Referred to Committee on Ways & Means.

AN ACT Relating to revising the medicaid nursing facility payment system by moving rebasing to even years, changing the case mix adjustment cycle to six months, establishing pay for performance, adjusting rates based upon rates of direct care staff turnover, and modifying components related to variable return, operations, property, and finance; amending RCW 74.46.431, 74.46.435, 74.46.437, 74.46.439, 74.46.496, 74.46.501, 74.46.506, and 74.46.521; adding a new section to chapter 74.46 RCW; repealing RCW 74.46.433; and declaring an emergency.

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

Sec. 1. RCW 74.46.431 and 2009 c 570 s 1 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~~)) six components: Direct care, therapy care, support services, operations, property, and financing allowance((~~, and variable return~~)). The department shall establish and adjust each of these components, as provided in this section and elsewhere in this chapter, for each medicaid nursing facility in this state.

(2) Component rate allocations in therapy care, support services, ((~~variable return,~~)) operations, property, and financing allowance 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,~~)) the component rate allocations in ((~~direct care,~~)) therapy care((~~,~~)) and support services((~~, and variable return~~)) shall be based upon a minimum facility occupancy of eighty-five percent of licensed beds. For ((~~all~~)) facilities other than essential community providers that have set up or use sixty beds or fewer, ((~~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~~)). For facilities other than essential community providers that have set up or use more than sixty beds, the component rate allocations in operations, property, and financing allowance shall be based upon a minimum facility occupancy of ninety-two percent of licensed beds. For all facilities, ((~~effective July 1, 2006,~~)) the component rate allocation in direct care shall be based upon actual facility occupancy. The median cost limits used to set component rate allocations shall be based on the applicable minimum occupancy percentage. In determining each facility's therapy care component rate allocation under RCW 74.46.511, the department shall apply the applicable minimum facility occupancy adjustment before creating the array of facilities' adjusted therapy costs per adjusted resident day. In determining each facility's support services component rate allocation under RCW 74.46.515(3), the department shall apply the applicable minimum facility occupancy adjustment before creating the array of facilities' adjusted support services costs per adjusted resident day. In determining each facility's operations component rate allocation under RCW 74.46.521(3), the department shall apply the minimum facility occupancy adjustment before creating the array of facilities' adjusted general operations costs per adjusted resident day.

(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, 2006, direct care component rate allocations. Adjusted cost report data from 2003 will be used for July 1, 2006, through June 30, 2007, direct care component rate allocations. Adjusted cost report data from 2005 will be used for July 1, 2007, through June 30, 2009, direct care component rate allocations.~~)) Effective July 1, 2009, the direct care component rate allocation shall be rebased ((~~biennially, and thereafter for each odd-numbered year beginning July 1st~~)), using the adjusted cost report data for the calendar year two years immediately preceding the rate rebase period, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, ((~~2011, 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) Direct care component rate allocations based on 2003 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, 2006, rate, as provided in RCW 74.46.506(5)(i).~~

~~(e)~~)) 2012. Beginning July 1, 2012, the direct care component rate allocation shall be rebased biennially during every even-numbered year thereafter using adjusted cost report data from two years prior to the rebase period, so adjusted cost report data for calendar year 2010 is used for July 1, 2012, through June 30, 2014, and so forth.

(b) Direct care component rate allocations established in accordance with this chapter shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. The economic trends and conditions factor or factors defined in the biennial appropriations act shall not be compounded with the economic trends and conditions factor or factors defined in any other biennial appropriations acts before applying it to the direct care component rate allocation established in accordance with this chapter. When no economic trends and conditions factor or factors for either fiscal year are defined in a biennial appropriations act, no economic trends and conditions factor or factors defined in any earlier biennial appropriations act shall be applied solely or compounded to the direct care component rate allocation established in accordance with this chapter.

(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, therapy care component rate allocations. Adjusted cost report data from 1999 will continue to be used for July 1, 2005, through June 30, 2007, therapy care component rate allocations. Adjusted cost report data from 2005 will be used for July 1, 2007, through June 30, 2009, therapy care component rate allocations.~~)) Effective July 1, 2009, ((~~and thereafter for each odd-numbered year beginning July 1st,~~)) the therapy care component rate allocation shall be cost rebased biennially, using the adjusted cost report data for the calendar year two years immediately preceding the

rate rebase period, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, ((~~2011~~)) 2012. Beginning July 1, 2012, the therapy care component rate allocation shall be rebased biennially during every even-numbered year thereafter using adjusted cost report data from two years prior to the rebase period, so adjusted cost report data for calendar year 2010 is used for July 1, 2012, through June 30, 2014, and so forth.

(b) Therapy care component rate allocations established in accordance with this chapter shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. The economic trends and conditions factor or factors defined in the biennial appropriations act shall not be compounded with the economic trends and conditions factor or factors defined in any other biennial appropriations acts before applying it to the therapy care component rate allocation established in accordance with this chapter. When no economic trends and conditions factor or factors for either fiscal year are defined in a biennial appropriations act, no economic trends and conditions factor or factors defined in any earlier biennial appropriations act shall be applied solely or compounded to the therapy care component rate allocation established in accordance with this chapter.

(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, support services component rate allocations. Adjusted cost report data from 1999 will continue to be used for July 1, 2005, through June 30, 2007, support services component rate allocations. Adjusted cost report data from 2005 will be used for July 1, 2007, through June 30, 2009, support services component rate allocations.~~)) Effective July 1, 2009, ((~~and thereafter for each odd-numbered year beginning July 1st,~~)) the support services component rate allocation shall be cost rebased biennially, using the adjusted cost report data for the calendar year two years immediately preceding the rate rebase period, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, ((~~2011~~)) 2012. Beginning July 1, 2012, the support services component rate

allocation shall be rebased biennially during every even-numbered year thereafter using adjusted cost report data from two years prior to the rebase period, so adjusted cost report data for calendar year 2010 is used for July 1, 2012, through June 30, 2014, and so forth.

(b) Support services component rate allocations established in accordance with this chapter shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. The economic trends and conditions factor or factors defined in the biennial appropriations act shall not be compounded with the economic trends and conditions factor or factors defined in any other biennial appropriations acts before applying it to the support services component rate allocation established in accordance with this chapter. When no economic trends and conditions factor or factors for either fiscal year are defined in a biennial appropriations act, no economic trends and conditions factor or factors defined in any earlier biennial appropriations act shall be applied solely or compounded to the support services component rate allocation established in accordance with this chapter.

(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, 2006, operations component rate allocations. Adjusted cost report data from 2003 will be used for July 1, 2006, through June 30, 2007, operations component rate allocations. Adjusted cost report data from 2005 will be used for July 1, 2007, through June 30, 2009, operations component rate allocations.~~)) Effective July 1, 2009, ((~~and thereafter for each odd-numbered year beginning July 1st,~~)) the operations component rate allocation shall be cost rebased biennially, using the adjusted cost report data for the calendar year two years immediately preceding the rate rebase period, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, ((~~2011~~)) 2012. Beginning July 1, 2012, the operations care component rate allocation shall be rebased biennially during every even-numbered year thereafter using adjusted cost report data from two years prior to the rebase period, so adjusted cost report data for

calendar year 2010 is used for July 1, 2012, through June 30, 2014, and so forth.

(b) Operations component rate allocations established in accordance with this chapter shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. The economic trends and conditions factor or factors defined in the biennial appropriations act shall not be compounded with the economic trends and conditions factor or factors defined in any other biennial appropriations acts before applying it to the operations component rate allocation established in accordance with this chapter. When no economic trends and conditions factor or factors for either fiscal year are defined in a biennial appropriations act, no economic trends and conditions factor or factors defined in any earlier biennial appropriations act shall be applied solely or compounded to the operations component rate allocation established in accordance with this chapter. ((~~A different economic trends and conditions adjustment factor or factors may be defined in the biennial appropriations act for facilities whose operations component rate is set equal to their adjusted June 30, 2006, rate, as provided in RCW 74.46.521(4).~~

~~(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)~~)) (8) 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)~~)) (9) 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 adjustments 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)~~)) (10) 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 component rate allocation shall be adjusted, without using the minimum occupancy assumption, for facilities that convert banked beds to active service, under chapter 70.38 RCW, beginning on July 1, 2006. Effective July 1, 2007, component rate allocations for direct care shall be based on actual patient days regardless of whether a facility has converted banked beds to active service.~~

~~(14)~~)) (11) 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 74.46.435 and 2001 1st sp.s. c 8 s 7 are each amended to read as follows:

(1) ((~~Effective July 1, 2001,~~)) T<u></u>he property component rate allocation for each facility shall be determined by dividing the sum of the reported allowable prior period actual depreciation, subject to ((~~RCW 74.46.310 through 74.46.380~~)) <u>department rule</u>, adjusted for any capitalized additions or replacements approved by the department, and the retained savings from such cost center, by the greater of a facility's total resident days for the facility in the prior period or resident days as calculated on ((~~eighty-five~~)) <u>ninety-two</u> percent facility occupancy <u>for all providers except (a) essential community providers and (b) nonessential community providers with sixty or fewer beds</u>. ((~~Effective July 1, 2002, the property component rate allocation for all facilities, except essential community providers, shall be set by using the greater of a facility's total resident days from the most recent cost report period or resident days calculated at ninety percent facility occupancy.~~)) If a capitalized addition or retirement of an asset will result in a different licensed bed capacity during the ensuing period, the prior period total resident days used in computing the property component rate shall be adjusted to anticipated resident day level.

(2) A nursing facility's property component rate allocation shall be rebased annually, effective July 1st, in accordance with this section and this chapter.

(3) When a certificate of need for a new facility is requested, the department, in reaching its decision, shall take into consideration per-bed land and building construction costs for the facility which shall not exceed a maximum to be established by the secretary.

(4) ((~~Effective July 1, 2001, for the purpose of calculating a nursing facility's property component rate, if a contractor has elected to bank licensed beds prior to April 1, 2001, or elects to convert banked beds to active service at any time, under chapter 70.38 RCW, the department shall use the facility's new licensed bed capacity to recalculate minimum occupancy for rate setting and revise the property component rate, as needed, effective as of the date the beds are banked~~

~~or converted to active service. However, in no case shall the department use less than eighty-five percent occupancy of the facility's licensed bed capacity after banking or conversion. Effective July 1, 2002,~~)) In no case, other than essential community providers or nonessential community providers with sixty beds or fewer, shall the department use less than ninety percent occupancy of the facility's licensed bed capacity after banking or conversion.

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

Sec. 3. RCW 74.46.437 and 2001 1st sp.s. c 8 s 8 are each amended to read as follows:

(1) ((~~Beginning July 1, 1999,~~)) The department shall establish for each medicaid nursing facility a financing allowance component rate allocation. The financing allowance component rate shall be rebased annually, effective July 1st, in accordance with the provisions of this section and this chapter.

(2) ((~~Effective July 1, 2001,~~)) The financing allowance shall be determined by multiplying the net invested funds of each facility by .10, and dividing by the greater of a nursing facility's total resident days from the most recent cost report period or resident days calculated on ((~~eighty-five~~)) ninety-two percent facility occupancy for all providers except (a) essential community providers and (b) nonessential community providers with sixty or fewer beds. ((~~Effective July 1, 2002, the financing allowance component rate allocation for all facilities, other than essential community providers, shall be set by using the greater of a facility's total resident days from the most recent cost report period or resident days calculated at ninety percent facility occupancy.~~)) However, assets acquired on or after May 17, 1999, shall be grouped in a separate financing allowance calculation that shall be multiplied by ((~~.085~~)) .075. The financing allowance factor of ((~~.085~~)) .075 shall not be applied to the net invested funds pertaining to new construction or major renovations receiving certificate of need approval or an exemption from certificate of need requirements under chapter 70.38 RCW, or to working drawings that have been submitted to the department of health for construction review approval, prior to May 17, 1999. If a capitalized addition,

renovation, replacement, or retirement of an asset will result in a different licensed bed capacity during the ensuing period, the prior period total resident days used in computing the financing allowance shall be adjusted to the greater of the anticipated resident day level or ((~~eighty-five~~)) ninety-two percent of the new licensed bed capacity for all providers except (a) essential community providers and (b) nonessential community providers with sixty or fewer beds. Effective July 1, 2002, for all facilities, other than essential community providers, the total resident days used to compute the financing allowance after a capitalized addition, renovation, replacement, or retirement of an asset shall be set by using the greater of a facility's total resident days from the most recent cost report period or resident days calculated at ninety-two percent facility occupancy.

(3) In computing the portion of net invested funds representing the net book value of tangible fixed assets, the same assets, depreciation bases, lives, and methods referred to in ((~~RCW 74.46.330, 74.46.350, 74.46.360, 74.46.370, and 74.46.380~~)) rule, including owned and leased assets, shall be utilized, except that the capitalized cost of land upon which the facility is located and such other contiguous land which is reasonable and necessary for use in the regular course of providing resident care shall also be included. Subject to provisions and limitations contained in this chapter, for land purchased by owners or lessors before July 18, 1984, capitalized cost of land shall be the buyer's capitalized cost. For all partial or whole rate periods after July 17, 1984, if the land is purchased after July 17, 1984, capitalized cost shall be that of the owner of record on July 17, 1984, or buyer's capitalized cost, whichever is lower. In the case of leased facilities where the net invested funds are unknown or the contractor is unable to provide necessary information to determine net invested funds, the secretary shall have the authority to determine an amount for net invested funds based on an appraisal conducted according to ((~~RCW 74.46.360(1)~~)) department rule.

(4) ((~~Effective July 1, 2001, for the purpose of calculating a nursing facility's financing allowance component rate, if a contractor has elected to bank licensed beds prior to May 25, 2001, or elects to convert banked beds to active service at any time, under chapter 70.38 RCW, the department shall use the facility's new licensed bed capacity to recalculate minimum occupancy for rate setting and revise the~~

~~financing allowance component rate, as needed, effective as of the date the beds are banked or converted to active service. However, in no case shall the department use less than eighty-five percent occupancy of the facility's licensed bed capacity after banking or conversion. Effective July 1, 2002,~~)) In no case, other than for essential community providers and nonessential community providers with sixty or fewer beds, shall the department use less than ninety-two percent occupancy of the facility's licensed bed capacity after conversion.

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

Sec. 4. RCW 74.46.439 and 1999 c 353 s 12 are each amended to read as follows:

(1) In the case of a facility that was leased by the contractor as of January 1, 1980, in an arm's-length agreement, which continues to be leased under the same lease agreement, ((~~and for which the annualized lease payment, plus any interest and depreciation expenses associated with contractor-owned assets, for the period covered by the prospective rates, divided by the contractor's total resident days, minus the property component rate allocation, is more than the sum of the financing allowance and the variable return rate determined according to this chapter, the following shall apply:~~

~~(a) The financing allowance shall be recomputed substituting the fair market value of the assets as of January 1, 1982, as determined by the department of general administration through an appraisal procedure, less accumulated depreciation on the lessor's assets since January 1, 1982, for the net book value of the assets in determining net invested funds for the facility. A determination by the department of general administration of fair market value shall be final unless the procedure used to make such a determination is shown to be arbitrary and capricious.~~

~~(b) The sum of the financing allowance computed under (a) of this subsection and the variable return rate shall be compared to the annualized lease payment, plus any interest and depreciation associated with contractor-owned assets, for the period covered by the prospective rates, divided by the contractor's total resident days, minus the~~

~~property component rate. The lesser of the two amounts shall be called the alternate return on investment rate.~~

~~(c) The sum of the financing allowance and variable return rate determined according to this chapter or the alternate return on investment rate, whichever is greater, shall be added to the prospective rates of the contractor.~~

~~(2) In the case of a facility that was leased by the contractor as of January 1, 1980, in an arm's-length agreement, if the lease is renewed or extended under a provision of the lease, the treatment provided in subsection (1) of this section shall be applied, except that in the case of renewals or extensions made subsequent to April 1, 1985, reimbursement for the annualized lease payment shall be no greater than the reimbursement for the annualized lease payment for the last year prior to the renewal or extension of the lease.~~

~~(3)~~)) the financing allowance rate will be the greater of the rate existing on June 30, 2010, or the rate calculated under RCW 74.46.437.

(2) The alternate return on investment component rate allocations calculated in accordance with this section shall be adjusted to the extent necessary to comply with RCW 74.46.421.

Sec. 5. RCW 74.46.496 and 2006 c 258 s 4 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 or six-month period during a calendar year 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~~)) United States department of health and human services 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 as provided in RCW 74.46.431(4).

Sec. 6. RCW 74.46.501 and 2006 c 258 s 5 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 based on the resident assessment instrument completed by the facility and the requirements and limitations for the instrument's completion and transmission (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~~)) specified by rule.

(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, 2006, 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 cost-rebasing period facility average case mix index will be used 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, 2006, 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~~)) semiannually shall be from the calendar ((~~quarter~~)) six-month period commencing ((~~six~~)) nine months prior to the effective date of the ((~~quarterly~~)) semiannual rate. For example, ((~~October 1, 1998~~)) July 1, 2010, through December 31, ((~~1998~~)) 2010, direct care component

rates shall utilize case mix averages from the ((~~April 1, 1998~~)) October 1, 2009, through ((~~June 30, 1998~~)) April 30, 2010, calendar quarters, and so forth.

Sec. 7. RCW 74.46.506 and 2007 c 508 s 3 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~~)) semiannually 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~~)) six-month period. 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 for rate periods as specified in RCW 74.46.431(4)(a).

(5) ((~~Beginning October 1, 1998,~~)) The department shall rebase each nursing facility's direct care component rate allocation as described in RCW 74.46.431, adjust its direct care component rate allocation for economic trends and conditions as described in RCW 74.46.431, and

update its medicaid average case mix index, consistent with the following:

(a) ((~~Reduce~~)) Adjust 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, 2006, each facility's allowable direct care costs shall be divided by its adjusted resident days without application of a minimum occupancy assumption~~));

(c) ((~~Adjust the facility's per resident day direct care cost by the applicable factor specified in RCW 74.46.431(4) 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)~~)) (6)(b) to derive the facility's allowable direct care cost per case mix unit;

((~~(e) Effective for July 1, 2001, rate setting,~~)) (d) 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)~~)) (e) 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, through June 30, 2006, 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) Between July 1, 2002, and June 30, 2006, all direct care component rate allocations shall be as determined under (h) of this subsection.~~

~~(iv) Effective July 1, 2006, for all providers, except vital local providers as defined in this chapter, all direct care component rate allocations shall be as determined under (j) of this subsection.~~

~~(v) Effective July 1, 2006, through June 30, 2007, for vital local providers, as defined in this chapter, direct care component rate allocations shall be determined as follows:~~

~~(A) The department shall calculate:~~

~~(I) The sum of each facility's July 1, 2006, direct care component~~

~~rate allocation calculated under (j) of this subsection and July 1, 2006, operations component rate calculated under RCW 74.46.521; and~~

~~(II) The sum of each facility's June 30, 2006, direct care and operations component rates.~~

~~(B) If the sum calculated under (i)(v)(A)(I) of this subsection is less than the sum calculated under (i)(v)(A)(II) of this subsection, the facility shall have a direct care component rate allocation equal to the facility's June 30, 2006, direct care component rate allocation.~~

~~(C) If the sum calculated under (i)(v)(A)(I) of this subsection is greater than or equal to the sum calculated under (i)(v)(A)(II) of this subsection, the facility's direct care component rate shall be calculated under (j) of this subsection;~~

~~(j) Except as provided in (i) of this subsection, from July 1, 2006, forward, and for all future rate setting,~~)) (f) Determine each facility's ((~~quarterly~~)) semiannual direct care component rate as follows:

(i) Any facility whose allowable cost per case mix unit is greater than one hundred twelve percent of the peer group median established under ((~~(f)~~)) (e) of this subsection shall be assigned a cost per case mix unit equal to one hundred twelve 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~~)) six-month period specified in RCW 74.46.501((~~(7)~~)) (6)(c);

(ii) Any facility whose allowable cost per case mix unit is less than or equal to one hundred twelve percent of the peer group median established under ((~~(f)~~)) (e) 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~~)) six-month period specified in RCW 74.46.501((~~(7)~~)) (6)(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) Costs related to 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. 8. RCW 74.46.521 and 2007 c 508 s 5 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, and financing allowance((~~, and variable return~~)).

(2) ((~~Except as provided in subsection (4) of this section, 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 and nonessential community providers with sixty or fewer beds shall be based upon a minimum occupancy of ninety-two 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) ((~~Except as provided in subsection (4) of this section,~~)) To determine each facility's operations component rate the department shall:

(a) Array facilities' adjusted general operations costs per adjusted resident day, as determined by dividing each facility's total allowable operations cost by its adjusted resident days for the same report period, increased if necessary to a minimum occupancy of ninety-two percent; that is, the greater of actual or imputed occupancy at ninety-two percent of licensed beds, 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-two 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).

(4)(((~~(a) Effective July 1, 2006, through June 30, 2007, for any facility whose direct care component rate allocation is set equal to its June 30, 2006, direct care component rate allocation, as provided in RCW 74.46.506(5), the facility's operations component rate allocation shall also be set equal to the facility's June 30, 2006, operations component rate allocation.~~

~~(b) The operations component rate allocation for facilities whose operations component rate is set equal to their June 30, 2006, operations component rate, shall be adjusted for economic trends and conditions as provided in RCW 74.46.431(7)(b).~~

~~(5)~~)) 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:

The department shall establish, by rule, the procedures, principles, and conditions for a pay for performance supplemental payment structure that provides payment add-ons for high performing facilities. To the extent that funds are appropriated for this purpose, the pay-for-performance structure will include a one percent reduction in payments to facilities with exceptionally high direct care staff turnover, and a method by which the funding that is not paid to these facilities is then used to provide a supplemental payment to facilities with lower direct care staff turnover.

NEW SECTION. **Sec. 10.** RCW 74.46.433 (Variable return component rate allocation) and 2006 c 258 s 3, 2001 1st sp.s. c 8 s 6, & 1999 c 353 s 9 are each repealed.

NEW SECTION. **Sec. 11.** 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 immediately.

--- END ---