Z-0276.3

HOUSE BILL 1249

State of Washington 62nd Legislature 2011 Regular Session

By Representatives Cody, Pettigrew, Hunter, and Darneille; by request of Department of Social and Health Services

Read first time 01/18/11. Referred to Committee on Ways & Means.

1 AN ACT Relating to ensuring efficient and economic medicaid nursing
2 facility payments; amending RCW 74.46.431, 74.46.437, 74.46.485,
3 74.46.496, and 74.46.501; repealing RCW 74.46.433; providing an
4 effective date; and declaring an emergency.

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

6 **Sec. 1.** RCW 74.46.431 and 2010 1st sp.s. c 34 s 3 are each amended
7 to read as follows:
8 (1) Nursing facility medicaid payment rate allocations shall be
9 facility-specific and shall have seven components: Direct care,
10 therapy care, support services, operations, property, financing
11 allowance, and variable return. The department shall establish and
12 adjust each of these components, as provided in this section and
13 elsewhere in this chapter, for each medicaid nursing facility in this
14 state.
15 (2) Component rate allocations in therapy care and support services
16 for all facilities shall be based upon a minimum facility occupancy of
17 eighty-five percent of licensed beds, regardless of how many beds are
18 set up or in use. Component rate allocations in operations, property,
19 and financing allowance for essential community providers 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. Component rate allocations in operations, property, and financing allowance for small nonessential community providers 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. Component rate allocations in operations, property, and financing allowance for large nonessential community providers shall be based upon a minimum facility occupancy of ninety-two percent of licensed beds, regardless of how many beds are set up or in use. For all facilities, 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. Effective July 1, 2009, the direct care component rate allocation shall be rebased, ((~~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, ((~~2012~~)) 2013. Beginning July 1, ((~~2012~~)) 2013, the direct care component rate allocation shall be rebased biennially during every ((~~even-numbered~~)) odd-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~~)) 2011 is used for July 1, ((~~2012~~)) 2013, through June 30, ((~~2014~~)) 2015, 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. Effective July 1, 2009, the therapy care component rate allocation shall be cost rebased, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, ((~~2012~~)) 2013. Beginning July 1, ((~~2012~~)) 2013, the therapy care component rate allocation shall be rebased biennially during every ((~~even-numbered~~)) odd-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~~)) 2011 is used for July 1, ((~~2012~~)) 2013, through June 30, ((~~2014~~)) 2015, 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. Effective July 1, 2009, the support services component rate allocation shall be cost rebased, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, ((~~2012~~)) 2013. Beginning July 1, ((~~2012~~)) 2013, the support services component rate allocation shall be rebased biennially during every ((~~even-numbered~~)) odd-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~~)) 2011 is used for July 1, ((~~2012~~)) 2013, through June 30, ((~~2014~~)) 2015, 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. Effective July 1, 2009, the operations component rate allocation shall be cost rebased, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, ((~~2012~~)) 2013. Beginning July 1, ((~~2012~~)) 2013, the operations care component rate

allocation shall be rebased biennially during every ((~~even-numbered~~)) odd-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~~)) 2011 is used for July 1, ((~~2012~~)) 2013, through June 30, ((~~2014~~)) 2015, 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.

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

(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: 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 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.

(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.

(11) Effective July 1, 2010, there shall be no rate adjustment for facilities with banked beds. For purposes of calculating minimum occupancy, licensed beds include any beds banked under chapter 70.38 RCW.

(12) 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 74.46.437 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~~)) is determined by multiplying the net invested funds of each facility by ((~~.10~~)) .04, 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 percent facility occupancy((~~. 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. The financing allowance factor of .085 shall not be applied to the net invested funds pertaining to new construction or major renovations receiving certificate of need approval or an exemption from certificate of need requirements under chapter 70.38 RCW, or to working drawings~~

~~that have been submitted to the department of health for construction review approval, prior to May 17, 1999~~)) for essential community providers, ninety percent facility occupancy for small nonessential community providers, or ninety-two percent occupancy for large nonessential community providers. 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 percent of the new licensed bed capacity for essential community providers, ninety percent facility occupancy for small nonessential community providers, or ninety-two percent occupancy for large nonessential community providers. ((~~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 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~~)) department 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~~)) must 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~~)) is 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~~)) is 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~~)) has the authority to determine an amount for net invested funds

1 based on an appraisal conducted according to ((~~RCW 74.46.360(1)~~))
2 department rule.
3 (4) ((~~Effective July 1, 2001, for the purpose of calculating a~~
4 ~~nursing facility's financing allowance component rate, if a contractor~~
5 ~~has elected to bank licensed beds prior to May 25, 2001, or elects to~~
6 ~~convert banked beds to active service at any time, under chapter 70.38~~
7 ~~RCW, the department shall use the facility's new licensed bed capacity~~
8 ~~to recalculate minimum occupancy for rate setting and revise the~~
9 ~~financing allowance component rate, as needed, effective as of the date~~
10 ~~the beds are banked or converted to active service. However, in no~~
11 ~~case shall the department use less than eighty-five percent occupancy~~
12 ~~of the facility's licensed bed capacity after banking or conversion.~~
13 ~~Effective July 1, 2002, in no case, other than for essential community~~
14 ~~providers, shall the department use less than ninety percent occupancy~~
15 ~~of the facility's licensed bed capacity after conversion.~~
16 ~~(5)~~)) The financing allowance rate allocation calculated in
17 accordance with this section shall be adjusted to the extent necessary
18 to comply with RCW 74.46.421.

19 **Sec. 3.** RCW 74.46.485 and 2010 1st sp.s. c 34 s 9 are each amended
20 to read as follows:
21 (1) The department shall:
22 (a) Employ the resource utilization group III case mix
23 classification methodology. The department shall use the forty-four
24 group index maximizing model for the resource utilization group III
25 grouper version 5.10, but the department may revise or update the
26 classification methodology to reflect advances or refinements in
27 resident assessment or classification, subject to federal requirements.
28 The department may adjust the case mix index for any of the lowest ten
29 resource utilization group categories beginning with PA1 through PE2 to
30 any case mix index that aids in achieving the purpose and intent of RCW
31 74.39A.007 and cost-efficient care; and
32 (b) Implement minimum data set 3.0 under the authority of this
33 section and RCW 74.46.431(3). The department must notify nursing home
34 contractors twenty-eight days in advance the date of implementation of
35 the minimum data set 3.0. In the notification, the department must
36 identify for all semiannual rate settings following the date of minimum
37 data set 3.0 implementation a previously established semiannual case

mix adjustment established for the semiannual rate settings that will be used for semiannual case mix calculations in direct care until minimum data set 3.0 is fully implemented. ((~~After the department has fully implemented minimum data set 3.0, it must adjust any semiannual rate setting in which it used the previously established case mix adjustment using the new minimum data set 3.0 data.~~))

(2) A default case mix group shall be established for cases in which the resident dies or is discharged for any purpose prior to completion of the resident's initial assessment. The default case mix group and case mix weight for these cases shall be designated by the department.

(3) A default case mix group may also be established for cases in which there is an untimely assessment for the resident. The default case mix group and case mix weight for these cases shall be designated by the department.

Sec. 4. RCW 74.46.496 and 2010 1st sp.s. c 34 s 10 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 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~~)) the lowest 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 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. 5. RCW 74.46.501 and 2010 1st sp.s. c 34 s 11 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) 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 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) 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. <u>To allow for the transition to minimum data set 3.0 and implementation of resource utilization group IV for the July 1, 2011, through July 1, 2012, cost-rebasing periods the department may determine the calendar quarter or quarters upon which the facility average case mix must be calculated.</u> A facility's medicaid average case mix index shall be used to update a nursing facility's direct care component rate semiannually.

(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 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. To allow for the transition to minimum data set 3.0 and implementation of resource utilization group IV for the July 1, 2011, through July 1, 2012, cost-rebasing periods the department may determine the calendar quarter or quarters upon which the facility average case mix must be calculated.

(c) The medicaid average case mix index used to update or recalibrate a nursing facility's direct care component rate semiannually shall be from the calendar six-month period commencing nine months prior to the effective date of the semiannual rate. For example, July 1, 2010, through December 31, 2010, direct care component rates shall utilize case mix averages from the October 1, 2009, through March 31, 2010, calendar quarters, and so forth.

NEW SECTION. **Sec. 6.** RCW 74.46.433 (Variable return component rate allocation) and 2010 1st sp.s. c 34 s 4, 2006 c 258 s 3, 2001 1st sp.s. c 8 s 6, & 1999 c 353 s 9 are each repealed.

NEW SECTION. **Sec. 7.** 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 March 1, 2011.

--- END ---