H-3083.1

HOUSE BILL 2236

State of Washington 63rd Legislature 2014 Regular Session

By Representatives Riccelli, Johnson, Tharinger, and Santos

Read first time 01/15/14. Referred to Committee on Appropriations.

1 AN ACT Relating to nursing homes; amending RCW 74.46.431,
2 74.46.435, 74.46.437, 74.46.506, 74.46.515, and 74.46.521; and adding
3 a new section to chapter 74.46 RCW.

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

5 **Sec. 1.** RCW 74.46.431 and 2013 2nd sp.s. c 3 s 1 are each amended
6 to read as follows:
7 (1) Nursing facility medicaid payment rate allocations shall be
8 facility-specific and shall have six components: Direct care, therapy
9 care, support services, operations, property, and financing allowance.
10 The department shall establish and adjust each of these components, as
11 provided in this section and elsewhere in this chapter, for each
12 medicaid nursing facility in this state.
13 (2) Component rate allocations in therapy care and support services
14 for all facilities shall be based upon a minimum facility occupancy of
15 eighty-five percent of licensed beds, regardless of how many beds are
16 set up or in use. Component rate allocations in operations, property,
17 and financing allowance for essential community providers shall be
18 based upon a minimum facility occupancy of ((~~eighty-seven~~)) eighty-five
19 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-two~~)) 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-five~~)) 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, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, 2015. Beginning July 1, 2015, the direct care component rate allocation shall be rebased biennially during every 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 2013 is used for July 1, 2015, through June 30, 2017, 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, 2015. Beginning July 1, 2015, the therapy care component rate allocation shall be rebased biennially during every 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 2013 is used for July 1, 2015, through June 30, 2017, 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

1 earlier biennial appropriations act shall be applied solely or
2 compounded to the therapy care component rate allocation established in
3 accordance with this chapter.
4 (6)(a) Support services component rate allocations shall be
5 established using adjusted cost report data covering at least six
6 months. Effective July 1, 2009, the support services component rate
7 allocation shall be cost rebased, so that adjusted cost report data for
8 calendar year 2007 is used for July 1, 2009, through June 30, 2015.
9 Beginning July 1, 2015, the support services component rate allocation
10 shall be rebased biennially during every odd-numbered year thereafter
11 using adjusted cost report data from two years prior to the rebase
12 period, so adjusted cost report data for calendar year 2013 is used for
13 July 1, 2015, through June 30, 2017, and so forth.
14 (b) Support services component rate allocations established in
15 accordance with this chapter shall be adjusted annually for economic
16 trends and conditions by a factor or factors defined in the biennial
17 appropriations act. The economic trends and conditions factor or
18 factors defined in the biennial appropriations act shall not be
19 compounded with the economic trends and conditions factor or factors
20 defined in any other biennial appropriations acts before applying it to
21 the support services component rate allocation established in
22 accordance with this chapter. When no economic trends and conditions
23 factor or factors for either fiscal year are defined in a biennial
24 appropriations act, no economic trends and conditions factor or factors
25 defined in any earlier biennial appropriations act shall be applied
26 solely or compounded to the support services component rate allocation
27 established in accordance with this chapter.
28 (7)(a) Operations component rate allocations shall be established
29 using adjusted cost report data covering at least six months.
30 Effective July 1, 2009, the operations component rate allocation shall
31 be cost rebased, so that adjusted cost report data for calendar year
32 2007 is used for July 1, 2009, through June 30, 2015. Beginning July
33 1, 2015, the operations care component rate allocation shall be rebased
34 biennially during every odd-numbered year thereafter using adjusted
35 cost report data from two years prior to the rebase period, so adjusted
36 cost report data for calendar year 2013 is used for July 1, 2015,
37 through June 30, 2017, 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 74.46.435 and 2011 1st sp.s. c 7 s 2 are each amended to read as follows:

(1) The property component rate allocation for each facility shall be determined by dividing the sum of the reported allowable prior period actual depreciation, subject to department rule, 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 in the prior period or resident days as calculated on ((~~eighty-seven~~)) eighty-five percent facility occupancy for essential community providers, ((~~ninety-two~~)) ninety percent occupancy for small nonessential community providers, or ((~~ninety-five~~)) ninety-two percent facility occupancy for large nonessential community providers. 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) 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.

1 **Sec. 3.** RCW 74.46.437 and 2011 1st sp.s. c 7 s 3 are each amended
2 to read as follows:
3 (1) The department shall establish for each medicaid nursing
4 facility a financing allowance component rate allocation. The
5 financing allowance component rate shall be rebased annually, effective
6 July 1st, in accordance with the provisions of this section and this
7 chapter.
8 (2) The financing allowance is determined by multiplying the net
9 invested funds of each facility by ((~~.04~~)) .085, and dividing by the
10 greater of a nursing facility's total resident days from the most
11 recent cost report period or resident days calculated on ((~~eighty-~~
12 ~~seven~~)) eighty-five percent facility occupancy for essential community
13 providers, ((~~ninety-two~~)) ninety percent facility occupancy for small
14 nonessential community providers, or ((~~ninety-five~~)) ninety-two percent
15 occupancy for large nonessential community providers. If a capitalized
16 addition, renovation, replacement, or retirement of an asset will
17 result in a different licensed bed capacity during the ensuing period,
18 the prior period total resident days used in computing the financing
19 allowance shall be adjusted to the greater of the anticipated resident
20 day level or ((~~eighty-seven~~)) eighty-five percent of the new licensed
21 bed capacity for essential community providers, ((~~ninety-two~~)) ninety
22 percent facility occupancy for small nonessential community providers,
23 or ((~~ninety-five~~)) ninety-two percent occupancy for large nonessential
24 community providers.
25 (3) In computing the portion of net invested funds representing the
26 net book value of tangible fixed assets, the same assets, depreciation
27 bases, lives, and methods referred to in department rule, including
28 owned and leased assets, shall be utilized, except that the capitalized
29 cost of land upon which the facility is located and such other
30 contiguous land which is reasonable and necessary for use in the
31 regular course of providing resident care must also be included.
32 Subject to provisions and limitations contained in this chapter, for
33 land purchased by owners or lessors before July 18, 1984, capitalized
34 cost of land is the buyer's capitalized cost. For all partial or whole
35 rate periods after July 17, 1984, if the land is purchased after July
36 17, 1984, capitalized cost is that of the owner of record on July 17,
37 1984, or buyer's capitalized cost, whichever is lower. In the case of
38 leased facilities where the net invested funds are unknown or the

1 contractor is unable to provide necessary information to determine net
2 invested funds, the secretary has the authority to determine an amount
3 for net invested funds based on an appraisal conducted according to
4 department rule.
5 (4) The financing allowance rate allocation calculated in
6 accordance with this section shall be adjusted to the extent necessary
7 to comply with RCW 74.46.421.

8 **Sec. 4.** RCW 74.46.506 and 2011 1st sp.s. c 7 s 7 are each amended
9 to read as follows:
10 (1) The direct care component rate allocation corresponds to the
11 provision of nursing care for one resident of a nursing facility for
12 one day, including direct care supplies. Therapy services and
13 supplies, which correspond to the therapy care component rate, shall be
14 excluded. The direct care component rate includes elements of case mix
15 determined consistent with the principles of this section and other
16 applicable provisions of this chapter.
17 (2) The department shall determine and update semiannually for each
18 nursing facility serving medicaid residents a facility-specific per-
19 resident day direct care component rate allocation, to be effective on
20 the first day of each six-month period. In determining direct care
21 component rates the department shall utilize, as specified in this
22 section, minimum data set resident assessment data for each resident of
23 the facility, as transmitted to, and if necessary corrected by, the
24 department in the resident assessment instrument format approved by
25 federal authorities for use in this state.
26 (3) The department may question the accuracy of assessment data for
27 any resident and utilize corrected or substitute information, however
28 derived, in determining direct care component rates. The department is
29 authorized to impose civil fines and to take adverse rate actions
30 against a contractor, as specified by the department in rule, in order
31 to obtain compliance with resident assessment and data transmission
32 requirements and to ensure accuracy.
33 (4) Cost report data used in setting direct care component rate
34 allocations shall be for rate periods as specified in RCW
35 74.46.431(4)(a).
36 (5) The department shall rebase each nursing facility's direct care
37 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 as described in RCW 74.46.496 and 74.46.501, consistent with the following:

(a) 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, to derive the facility's allowable direct care cost per resident day;

(c) 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(6)(b) to derive the facility's allowable direct care cost per case mix unit;

(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;

(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;

(f) Determine each facility's semiannual direct care component rate as follows:

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

(ii) Any facility whose allowable cost per case mix unit is less than or equal to one hundred ((~~ten~~)) twelve percent of the peer group median established under (e) of this subsection shall have a direct

1 care component rate allocation equal to the facility's allowable cost
2 per case mix unit multiplied by that facility's medicaid average case
3 mix index from the applicable six-month period specified in RCW
4 74.46.501(6)(c).
5 (6) The direct care component rate allocations calculated in
6 accordance with this section shall be adjusted to the extent necessary
7 to comply with RCW 74.46.421.
8 (7) Costs related to payments resulting from increases in direct
9 care component rates, granted under authority of RCW 74.46.508 for a
10 facility's exceptional care residents, shall be offset against the
11 facility's examined, allowable direct care costs, for each report year
12 or partial period such increases are paid. Such reductions in
13 allowable direct care costs shall be for rate setting, settlement, and
14 other purposes deemed appropriate by the department.

15 **Sec. 5.** RCW 74.46.515 and 2011 1st sp.s. c 7 s 8 are each amended
16 to read as follows:
17 (1) The support services component rate allocation corresponds to
18 the provision of food, food preparation, dietary, housekeeping, and
19 laundry services for one resident for one day.
20 (2) The department shall determine each medicaid nursing facility's
21 support services component rate allocation using cost report data
22 specified by RCW 74.46.431(6).
23 (3) To determine each facility's support services component rate
24 allocation, the department shall:
25 (a) Array facilities' adjusted support services costs per adjusted
26 resident day, as determined by dividing each facility's total allowable
27 support services costs by its adjusted resident days for the same
28 report period, increased if necessary to a minimum occupancy provided
29 by RCW 74.46.431(2), for each facility from facilities' cost reports
30 from the applicable report year, for facilities located within urban
31 counties, and for those located within nonurban counties and determine
32 the median adjusted cost for each peer group;
33 (b) Set each facility's support services component rate at the
34 lower of the facility's per resident day adjusted support services
35 costs from the applicable cost report period or the adjusted median per
36 resident day support services cost for that facility's peer group,

either urban counties or nonurban counties, plus ((~~eight~~)) ten percent; and

(c) Adjust each facility's support services component rate for economic trends and conditions as provided in RCW 74.46.431(6).

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

Sec. 6. RCW 74.46.521 and 2011 1st sp.s. c 7 s 9 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) 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). Operations component rates for essential community providers shall be based upon a minimum occupancy of ((~~eighty-seven~~)) eighty-five percent of licensed beds. Operations component rates for small nonessential community providers shall be based upon a minimum occupancy of ((~~ninety-two~~)) ninety percent of licensed beds. Operations component rates for large nonessential community providers shall be based upon a minimum occupancy of ((~~ninety-five~~)) ninety-two percent of licensed beds.

(3) For all calculations and adjustments in this subsection, the department shall use the greater of the facility's actual occupancy or an occupancy equal to ((~~eighty-seven~~)) eighty-five percent for essential community providers, ((~~ninety-two~~)) ninety percent for small nonessential community providers, or ((~~ninety-five~~)) ninety-two percent for large nonessential community providers. 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

1 report period for facilities located within urban counties and for
2 those located within nonurban counties and determine the median
3 adjusted cost for each peer group;
4 (b) Set each facility's operations component rate at the lower of:
5 (i) The facility's per resident day adjusted operations costs from
6 the applicable cost report period adjusted if necessary for minimum
7 occupancy; or
8 (ii) The adjusted median per resident day general operations cost
9 for that facility's peer group, urban counties or nonurban counties;
10 and
11 (c) Adjust each facility's operations component rate for economic
12 trends and conditions as provided in RCW 74.46.431(7)(b).
13 (4) The operations component rate allocations calculated in
14 accordance with this section shall be adjusted to the extent necessary
15 to comply with RCW 74.46.421.

16 NEW SECTION. **Sec. 7.** A new section is added to chapter 74.46 RCW
17 to read as follows:
18 (1) Effective July 1, 2014, the department shall establish a
19 disproportionate medicaid share rate add-on using an array of
20 facilities.
21 (a) To calculate the array of facilities, the department, without
22 using peer groups, shall first rank all facilities in numerical order
23 from highest to lowest according to each facility's examined and
24 documented medicaid occupancy as a percentage of total occupancy based
25 upon medicaid days compared to total resident days from the applicable
26 cost report period specified in RCW 74.46.431(7)(a). The array shall
27 then be divided into four quartiles, each containing, as nearly as
28 possible, an equal number of facilities, and one percent shall be
29 assigned to the lowest quartile, three percent to facilities in the
30 next lowest quartile, four and one-half percent to facilities in the
31 next highest quartile, and five and one-half percent to facilities in
32 the highest quartile.
33 (b) The department shall compute the disproportionate medicaid
34 share add-on by multiplying a facility's assigned percentage by the sum
35 of the facility's direct care, therapy care, support services, and
36 operations component rates determined in accordance with this chapter
37 and rules adopted by the department.

1 (c) The disproportionate medicaid share array, with subsequent
2 reassignment of quartiles, if any, shall be calculated on an annual
3 basis, effective July 1, using the most recently filed cost report
4 information.
5 (2) The disproportionate medicaid share add-on calculated in
6 accordance with this section shall be adjusted to the extent necessary
7 to comply with RCW 74.46.421.
8 (3) The disproportionate medicaid share add-on shall not be subject
9 to the settlement provisions of RCW 74.46.022(6).
10 (4) The disproportionate medicaid share add-on shall not be
11 included in or subject to the comparative analysis calculation
12 described in section 11, chapter 7, Laws of 2011 1st sp. sess. and
13 section 3, chapter 3, Laws of 2013 2nd sp. sess., or subsequent and
14 similar comparative analysis.

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