Z-0010.5

SENATE BILL 5041

State of Washington 62nd Legislature 2011 Regular Session

By Senator Keiser; by request of Department of Social and Health Services

Read first time 01/11/11. Referred to Committee on Health & Long-Term Care.

AN ACT Relating to the direct care and financing allowance component rate allocations for medicaid nursing facilities; and amending RCW 74.46.437, 74.46.485, and 74.46.501.

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

Sec. 1. 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, 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~~)) for essential community providers, ninety percent facility occupancy for small nonessential community providers, or ninety-two percent facility occupancy for large nonessential community providers. 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. 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((~~. 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~~)) for essential community providers, ninety percent of the new licensed bed capacity for small nonessential community providers, or ninety-two percent of the new licensed bed capacity for large nonessential community providers.

(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 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 based on an appraisal conducted according to ((~~RCW 74.46.360(1).~~

~~(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, shall the department use less than ninety percent occupancy of the facility's licensed bed capacity after conversion.~~

~~(5)~~)) department rule.

(4) 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. 2. RCW 74.46.485 and 2010 1st sp.s. c 34 s 9 are each amended to read as follows:

(1) The department shall:

(a) Employ the resource utilization group III case mix classification methodology. The department shall use the forty-four group index maximizing model for the resource utilization group III grouper version 5.10, but the department may revise or update the classification methodology to reflect advances or refinements in resident assessment or classification, subject to federal requirements; and

(b) Implement minimum data set 3.0 under the authority of this section and RCW 74.46.431(3). The department must notify nursing home

contractors twenty-eight days in advance the date of implementation of the minimum data set 3.0. In the notification, the department must identify for all semiannual rate settings following the date of minimum 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. 3. 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. To allow for the transition to MDS 3.0 and implementation of RUG IV, for the July 1, 2011, through July 1, 2012, cost-rebasing periods the department may determine the calendar quarter(s) upon which the facility average case mix index will be calculated. 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 MDS 3.0 and implementation of RUG IV, for the July 1, 2011, through July 1, 2012, cost-rebasing periods the department may determine the calendar quarter(s) upon which the facility average case mix index will 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.

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