
SENATE BILL 5466

State of Washington

62nd Legislature

2011 Regular Session

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

Read first time 01/26/11. Referred to Committee on Health & Long-Term Care.

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

1 based upon a minimum facility occupancy of eighty-five percent of
2 licensed beds, regardless of how many beds are set up or in use.
3 Component rate allocations in operations, property, and financing
4 allowance for small nonessential community providers shall be based
5 upon a minimum facility occupancy of ninety percent of licensed beds,
6 regardless of how many beds are set up or in use. Component rate
7 allocations in operations, property, and financing allowance for large
8 nonessential community providers shall be based upon a minimum facility
9 occupancy of ninety-two percent of licensed beds, regardless of how
10 many beds are set up or in use. For all facilities, the component rate
11 allocation in direct care shall be based upon actual facility
12 occupancy. The median cost limits used to set component rate
13 allocations shall be based on the applicable minimum occupancy
14 percentage. In determining each facility's therapy care component rate
15 allocation under RCW 74.46.511, the department shall apply the
16 applicable minimum facility occupancy adjustment before creating the
17 array of facilities' adjusted therapy costs per adjusted resident day.
18 In determining each facility's support services component rate
19 allocation under RCW 74.46.515(3), the department shall apply the
20 applicable minimum facility occupancy adjustment before creating the
21 array of facilities' adjusted support services costs per adjusted
22 resident day. In determining each facility's operations component rate
23 allocation under RCW 74.46.521(3), the department shall apply the
24 minimum facility occupancy adjustment before creating the array of
25 facilities' adjusted general operations costs per adjusted resident
26 day.

27 (3) Information and data sources used in determining medicaid
28 payment rate allocations, including formulas, procedures, cost report
29 periods, resident assessment instrument formats, resident assessment
30 methodologies, and resident classification and case mix weighting
31 methodologies, may be substituted or altered from time to time as
32 determined by the department.

33 (4)(a) Direct care component rate allocations shall be established
34 using adjusted cost report data covering at least six months.
35 Effective July 1, 2009, the direct care component rate allocation shall
36 be rebased, (~~using the adjusted cost report data for the calendar year~~
37 ~~two years immediately preceding the rate rebase period,~~) so that
38 adjusted cost report data for calendar year 2007 is used for July 1,

1 2009, through June 30, (~~(2012)~~) 2013. Beginning July 1, (~~(2012)~~) 2013,
2 the direct care component rate allocation shall be rebased biennially
3 during every (~~(even-numbered)~~) odd-numbered year thereafter using
4 adjusted cost report data from two years prior to the rebase period, so
5 adjusted cost report data for calendar year (~~(2010)~~) 2011 is used for
6 July 1, (~~(2012)~~) 2013, through June 30, (~~(2014)~~) 2015, and so forth.

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

21 (5)(a) Therapy care component rate allocations shall be established
22 using adjusted cost report data covering at least six months.
23 Effective July 1, 2009, the therapy care component rate allocation
24 shall be cost rebased, so that adjusted cost report data for calendar
25 year 2007 is used for July 1, 2009, through June 30, (~~(2012)~~) 2013.
26 Beginning July 1, (~~(2012)~~) 2013, the therapy care component rate
27 allocation shall be rebased biennially during every (~~(even-numbered)~~)
28 odd-numbered year thereafter using adjusted cost report data from two
29 years prior to the rebase period, so adjusted cost report data for
30 calendar year (~~(2010)~~) 2011 is used for July 1, (~~(2012)~~) 2013, through
31 June 30, (~~(2014)~~) 2015, and so forth.

32 (b) Therapy care component rate allocations established in
33 accordance with this chapter shall be adjusted annually for economic
34 trends and conditions by a factor or factors defined in the biennial
35 appropriations act. The economic trends and conditions factor or
36 factors defined in the biennial appropriations act shall not be
37 compounded with the economic trends and conditions factor or factors
38 defined in any other biennial appropriations acts before applying it to

1 the therapy care component rate allocation established in accordance
2 with this chapter. When no economic trends and conditions factor or
3 factors for either fiscal year are defined in a biennial appropriations
4 act, no economic trends and conditions factor or factors defined in any
5 earlier biennial appropriations act shall be applied solely or
6 compounded to the therapy care component rate allocation established in
7 accordance with this chapter.

8 (6)(a) Support services component rate allocations shall be
9 established using adjusted cost report data covering at least six
10 months. Effective July 1, 2009, the support services component rate
11 allocation shall be cost rebased, so that adjusted cost report data for
12 calendar year 2007 is used for July 1, 2009, through June 30, (~~2012~~)
13 2013. Beginning July 1, (~~2012~~) 2013, the support services component
14 rate allocation shall be rebased biennially during every (~~even-~~
15 ~~numbered~~) odd-numbered year thereafter using adjusted cost report data
16 from two years prior to the rebase period, so adjusted cost report data
17 for calendar year (~~2010~~) 2011 is used for July 1, (~~2012~~) 2013,
18 through June 30, (~~2014~~) 2015, and so forth.

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

33 (7)(a) Operations component rate allocations shall be established
34 using adjusted cost report data covering at least six months.
35 Effective July 1, 2009, the operations component rate allocation shall
36 be cost rebased, so that adjusted cost report data for calendar year
37 2007 is used for July 1, 2009, through June 30, (~~2012~~) 2013.
38 Beginning July 1, (~~2012~~) 2013, the operations care component rate

1 allocation shall be rebased biennially during every (~~even-numbered~~)
2 odd-numbered year thereafter using adjusted cost report data from two
3 years prior to the rebase period, so adjusted cost report data for
4 calendar year (~~(2010)~~) 2011 is used for July 1, (~~(2012)~~) 2013, through
5 June 30, (~~(2014)~~) 2015, and so forth.

6 (b) Operations component rate allocations established in accordance
7 with this chapter shall be adjusted annually for economic trends and
8 conditions by a factor or factors defined in the biennial
9 appropriations act. The economic trends and conditions factor or
10 factors defined in the biennial appropriations act shall not be
11 compounded with the economic trends and conditions factor or factors
12 defined in any other biennial appropriations acts before applying it to
13 the operations component rate allocation established in accordance with
14 this chapter. When no economic trends and conditions factor or factors
15 for either fiscal year are defined in a biennial appropriations act, no
16 economic trends and conditions factor or factors defined in any earlier
17 biennial appropriations act shall be applied solely or compounded to
18 the operations component rate allocation established in accordance with
19 this chapter.

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

23 (9) The department shall establish in rule procedures, principles,
24 and conditions for determining component rate allocations for
25 facilities in circumstances not directly addressed by this chapter,
26 including but not limited to: Inflation adjustments for partial-period
27 cost report data, newly constructed facilities, existing facilities
28 entering the medicaid program for the first time or after a period of
29 absence from the program, existing facilities with expanded new bed
30 capacity, existing medicaid facilities following a change of ownership
31 of the nursing facility business, facilities temporarily reducing the
32 number of set-up beds during a remodel, facilities having less than six
33 months of either resident assessment, cost report data, or both, under
34 the current contractor prior to rate setting, and other circumstances.

35 (10) The department shall establish in rule procedures, principles,
36 and conditions, including necessary threshold costs, for adjusting
37 rates to reflect capital improvements or new requirements imposed by

1 the department or the federal government. Any such rate adjustments
2 are subject to the provisions of RCW 74.46.421.

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

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

15 **Sec. 2.** RCW 74.46.437 and 2001 1st sp.s. c 8 s 8 are each amended
16 to read as follows:

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

22 (2) ~~((Effective July 1, 2001,))~~ The financing allowance ~~((shall
23 be))~~ is determined by multiplying the net invested funds of each
24 facility by ~~((-.10))~~ .04, and dividing by the greater of a nursing
25 facility's total resident days from the most recent cost report period
26 or resident days calculated on eighty-five percent facility
27 occupancy~~((. Effective July 1, 2002, the financing allowance component
28 rate allocation for all facilities, other than essential community
29 providers, shall be set by using the greater of a facility's total
30 resident days from the most recent cost report period or resident days
31 calculated at ninety percent facility occupancy. However, assets
32 acquired on or after May 17, 1999, shall be grouped in a separate
33 financing allowance calculation that shall be multiplied by .085. The
34 financing allowance factor of .085 shall not be applied to the net
35 invested funds pertaining to new construction or major renovations
36 receiving certificate of need approval or an exemption from certificate
37 of need requirements under chapter 70.38 RCW, or to working drawings~~

1 ~~that have been submitted to the department of health for construction~~
2 ~~review approval, prior to May 17, 1999))~~ for essential community
3 providers, ninety percent facility occupancy for small nonessential
4 community providers, or ninety-two percent occupancy for large
5 nonessential community providers. If a capitalized addition,
6 renovation, replacement, or retirement of an asset will result in a
7 different licensed bed capacity during the ensuing period, the prior
8 period total resident days used in computing the financing allowance
9 shall be adjusted to the greater of the anticipated resident day level
10 or eighty-five percent of the new licensed bed capacity for essential
11 community providers, ninety percent facility occupancy for small
12 nonessential community providers, or ninety-two percent occupancy for
13 large nonessential community providers. (~~Effective July 1, 2002, for~~
14 ~~all facilities, other than essential community providers, the total~~
15 ~~resident days used to compute the financing allowance after a~~
16 ~~capitalized addition, renovation, replacement, or retirement of an~~
17 ~~asset shall be set by using the greater of a facility's total resident~~
18 ~~days from the most recent cost report period or resident days~~
19 ~~calculated at ninety percent facility occupancy.))~~)

20 (3) In computing the portion of net invested funds representing the
21 net book value of tangible fixed assets, the same assets, depreciation
22 bases, lives, and methods referred to in (~~RCW 74.46.330, 74.46.350,~~
23 ~~74.46.360, 74.46.370, and 74.46.380))~~ department rule, including owned
24 and leased assets, shall be utilized, except that the capitalized cost
25 of land upon which the facility is located and such other contiguous
26 land which is reasonable and necessary for use in the regular course of
27 providing resident care (~~shall~~) must also be included. Subject to
28 provisions and limitations contained in this chapter, for land
29 purchased by owners or lessors before July 18, 1984, capitalized cost
30 of land (~~shall be~~) is the buyer's capitalized cost. For all partial
31 or whole rate periods after July 17, 1984, if the land is purchased
32 after July 17, 1984, capitalized cost (~~shall be~~) is that of the owner
33 of record on July 17, 1984, or buyer's capitalized cost, whichever is
34 lower. In the case of leased facilities where the net invested funds
35 are unknown or the contractor is unable to provide necessary
36 information to determine net invested funds, the secretary (~~shall~~
37 ~~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

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

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

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

16 **Sec. 4.** RCW 74.46.496 and 2010 1st sp.s. c 34 s 10 are each
17 amended to read as follows:

18 (1) Each case mix classification group shall be assigned a case mix
19 weight. The case mix weight for each resident of a nursing facility
20 for each calendar quarter or six-month period during a calendar year
21 shall be based on data from resident assessment instruments completed
22 for the resident and weighted by the number of days the resident was in
23 each case mix classification group. Days shall be counted as provided
24 in this section.

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

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

35 (a) Set the certified nurse aide wage weight at 1.000 and calculate
36 wage weights for registered nurse and licensed practical nurse average

1 wages by dividing the certified nurse aide average wage into the
2 registered nurse average wage and licensed practical nurse average
3 wage;

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

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

15 (4) The case mix weights in this state may be revised if the United
16 States department of health and human services updates its nursing
17 facility staff time measurement studies. The case mix weights shall be
18 revised, but only when direct care component rates are cost-rebased as
19 provided in subsection (5) of this section, to be effective on the July
20 1st effective date of each cost-rebased direct care component rate.
21 However, the department may revise case mix weights more frequently if,
22 and only if, significant variances in wage ratios occur among direct
23 care staff in the different caregiver classifications identified in
24 this section.

25 (5) Case mix weights shall be revised when direct care component
26 rates are cost-rebased as provided in RCW 74.46.431(4).

27 **Sec. 5.** RCW 74.46.501 and 2010 1st sp.s. c 34 s 11 are each
28 amended to read as follows:

29 (1) From individual case mix weights for the applicable quarter,
30 the department shall determine two average case mix indexes for each
31 medicaid nursing facility, one for all residents in the facility, known
32 as the facility average case mix index, and one for medicaid residents,
33 known as the medicaid average case mix index.

34 (2)(a) In calculating a facility's two average case mix indexes for
35 each quarter, the department shall include all residents or medicaid
36 residents, as applicable, who were physically in the facility during
37 the quarter in question based on the resident assessment instrument

1 completed by the facility and the requirements and limitations for the
2 instrument's completion and transmission (January 1st through March
3 31st, April 1st through June 30th, July 1st through September 30th, or
4 October 1st through December 31st).

5 (b) The facility average case mix index shall exclude all default
6 cases as defined in this chapter. However, the medicaid average case
7 mix index shall include all default cases.

8 (3) Both the facility average and the medicaid average case mix
9 indexes shall be determined by multiplying the case mix weight of each
10 resident, or each medicaid resident, as applicable, by the number of
11 days, as defined in this section and as applicable, the resident was at
12 each particular case mix classification or group, and then averaging.

13 (4) In determining the number of days a resident is classified into
14 a particular case mix group, the department shall determine a start
15 date for calculating case mix grouping periods as specified by rule.

16 (5) The cutoff date for the department to use resident assessment
17 data, for the purposes of calculating both the facility average and the
18 medicaid average case mix indexes, and for establishing and updating a
19 facility's direct care component rate, shall be one month and one day
20 after the end of the quarter for which the resident assessment data
21 applies.

22 (6)(a) Although the facility average and the medicaid average case
23 mix indexes shall both be calculated quarterly, the cost-rebasing
24 period facility average case mix index will be used throughout the
25 applicable cost-rebasing period in combination with cost report data as
26 specified by RCW 74.46.431 and 74.46.506, to establish a facility's
27 allowable cost per case mix unit. To allow for the transition to
28 minimum data set 3.0 and implementation of resource utilization group
29 IV for the July 1, 2011, through July 1, 2012, cost-rebasing periods
30 the department may determine the calendar quarter or quarters upon
31 which the facility average case mix must be calculated. A facility's
32 medicaid average case mix index shall be used to update a nursing
33 facility's direct care component rate semiannually.

34 (b) The facility average case mix index used to establish each
35 nursing facility's direct care component rate shall be based on an
36 average of calendar quarters of the facility's average case mix indexes
37 from the four calendar quarters occurring during the cost report period
38 used to rebase the direct care component rate allocations as specified

1 in RCW 74.46.431. To allow for the transition to minimum data set 3.0
2 and implementation of resource utilization group IV for the July 1,
3 2011, through July 1, 2012, cost-rebasing periods the department may
4 determine the calendar quarter or quarters upon which the facility
5 average case mix must be calculated.

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

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

16 NEW SECTION. Sec. 7. This act is necessary for the immediate
17 preservation of the public peace, health, or safety, or support of the
18 state government and its existing public institutions, and takes effect
19 March 1, 2011.

--- END ---