Z-0866.1

# SENATE BILL 6629

**State of Washington 60th Legislature 2008 Regular Session**

**By** Senators Franklin and Prentice; by request of Department of Social and Health Services

Read first time 01/21/08. Referred to Committee on Ways & Means.

AN ACT Relating to making clarifications to the nursing facility medicaid payment system in relation to the use of minimum occupancy in setting cost limits and application of the statewide average payment rate specified in the biennial appropriations act; amending RCW 74.46.421, 74.46.431, 74.46.511, and 74.46.515; and creating a new section.

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

**Sec. 1.** RCW 74.46.421 and 2001 1st sp.s. c 8 s 4 are each amended to read as follows:

(1) The purpose of part E of this chapter is to determine nursing facility medicaid payment rates that, in the aggregate for all participating nursing facilities, are in accordance with the biennial appropriations act.

(2)(a) The department shall use the nursing facility medicaid payment rate methodologies described in this chapter to determine initial component rate allocations for each medicaid nursing facility.

(b) The initial component rate allocations shall be subject to adjustment as provided in this section in order to assure that the

statewide average payment rate to nursing facilities is less than or equal to the statewide average payment rate specified in the biennial appropriations act.

(3) Nothing in this chapter shall be construed as creating a legal right or entitlement to any payment that (a) has not been adjusted under this section or (b) would cause the statewide average payment rate to exceed the statewide average payment rate specified in the biennial appropriations act.

(4)(a) The statewide average payment rate for any state fiscal year under the nursing facility payment system, weighted by patient days, shall not exceed the annual statewide weighted average nursing facility payment rate identified for that fiscal year in the biennial appropriations act.

(b) If the department determines that the weighted average nursing facility payment rate calculated in accordance with this chapter is likely to exceed the weighted average nursing facility payment rate identified in the biennial appropriations act, then the department shall adjust all nursing facility payment rates proportional to the amount by which the weighted average rate allocations would otherwise exceed the budgeted rate amount. Any such adjustments <u>for the current fiscal year</u> shall only be made prospectively, not retrospectively, and shall be applied proportionately to each component rate allocation for each facility.

<u>(c) If any final order or final judgment, including a final order or final judgment resulting from an adjudicative proceeding or judicial review permitted by chapter 34.05 RCW, affects a nursing facility's payment rate for a prior fiscal year or years, the department shall retrospectively adjust payment rates for such fiscal year or years to the extent necessary to comply with this section. The department shall consider the payment rates for all nursing facilities for such fiscal year or years in determining whether the statewide weighted average payment rate for such fiscal year or years would be exceeded as a result of the final order or final judgment. However, in making retrospective adjustments to comply with this subsection, the department shall adjust the payment rate or rates for the fiscal year or years in question of only the nursing facility or facilities affected by the final order or final judgment.</u>

**Sec. 2.** RCW 74.46.431 and 2007 c 508 s 2 are each amended to read as follows:

(1) Effective July 1, 1999, nursing facility medicaid payment rate allocations shall be facility-specific and shall have seven components: Direct care, therapy care, support services, operations, property, financing allowance, and variable return. The department shall establish and adjust each of these components, as provided in this section and elsewhere in this chapter, for each medicaid nursing facility in this state.

(2) Component rate allocations in therapy care, support services, variable return, operations, property, and financing allowance for essential community providers as defined in this chapter shall be based upon a minimum facility occupancy of eighty-five percent of licensed beds, regardless of how many beds are set up or in use. For all facilities other than essential community providers, effective July 1, 2001, component rate allocations in direct care, therapy care, support services, and variable return((~~, operations, property, and financing allowance~~)) shall ((~~continue to~~)) be based upon a minimum facility occupancy of eighty-five percent of licensed beds. For all facilities other than essential community providers, effective July 1, 2002, the component rate allocations in operations, property, and financing allowance shall be based upon a minimum facility occupancy of ninety percent of licensed beds, regardless of how many beds are set up or in use. For all facilities, effective July 1, 2006, the component rate allocation in direct care shall be based upon actual facility occupancy. The median cost limits used to set component rate allocations shall be based on the applicable minimum occupancy percentage. In determining each facility's therapy care component rate allocation under RCW 74.46.511, the department shall apply the applicable minimum facility occupancy adjustment before creating the array of facilities' adjusted therapy costs per adjusted resident day. In determining each facility's support services component rate allocation under RCW 74.46.515(3), the department shall apply the applicable minimum facility occupancy adjustment before creating the array of facilities' adjusted support services costs per adjusted resident day. In determining each facility's operations component rate allocation under RCW 74.46.521(3), the department shall apply the

minimum facility occupancy adjustment before creating the array of facilities' adjusted general operations costs per adjusted resident day.

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

(4)(a) Direct care component rate allocations shall be established using adjusted cost report data covering at least six months. Adjusted cost report data from 1996 will be used for October 1, 1998, through June 30, 2001, direct care component rate allocations; adjusted cost report data from 1999 will be used for July 1, 2001, through June 30, 2006, direct care component rate allocations. Adjusted cost report data from 2003 will be used for July 1, 2006, through June 30, 2007, direct care component rate allocations. Adjusted cost report data from 2005 will be used for July 1, 2007, through June 30, 2009, direct care component rate allocations. Effective July 1, 2009, the direct care component rate allocation shall be rebased biennially, and thereafter for each odd-numbered year beginning July 1st, using the adjusted cost report data for the calendar year two years immediately preceding the rate rebase period, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, 2011, and so forth.

(b) Direct care component rate allocations based on 1996 cost report data shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. A different economic trends and conditions adjustment factor or factors may be defined in the biennial appropriations act for facilities whose direct care component rate is set equal to their adjusted June 30, 1998, rate, as provided in RCW 74.46.506(5)(i).

(c) Direct care component rate allocations based on 1999 cost report data shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. A different economic trends and conditions adjustment factor or factors may be defined in the biennial

appropriations act for facilities whose direct care component rate is set equal to their adjusted June 30, 1998, rate, as provided in RCW 74.46.506(5)(i).

(d) Direct care component rate allocations based on 2003 cost report data shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. A different economic trends and conditions adjustment factor or factors may be defined in the biennial appropriations act for facilities whose direct care component rate is set equal to their adjusted June 30, 2006, rate, as provided in RCW 74.46.506(5)(i).

(e) Direct care component rate allocations shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act.

(5)(a) Therapy care component rate allocations shall be established using adjusted cost report data covering at least six months. Adjusted cost report data from 1996 will be used for October 1, 1998, through June 30, 2001, therapy care component rate allocations; adjusted cost report data from 1999 will be used for July 1, 2001, through June 30, 2005, therapy care component rate allocations. Adjusted cost report data from 1999 will continue to be used for July 1, 2005, through June 30, 2007, therapy care component rate allocations. Adjusted cost report data from 2005 will be used for July 1, 2007, through June 30, 2009, therapy care component rate allocations. Effective July 1, 2009, and thereafter for each odd-numbered year beginning July 1st, the therapy care component rate allocation shall be cost rebased biennially, using the adjusted cost report data for the calendar year two years immediately preceding the rate rebase period, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, 2011, and so forth.

(b) Therapy care component rate allocations shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act.

(6)(a) Support services component rate allocations shall be established using adjusted cost report data covering at least six months. Adjusted cost report data from 1996 shall be used for October 1, 1998, through June 30, 2001, support services component rate allocations; adjusted cost report data from 1999 shall be used for July

1, 2001, through June 30, 2005, support services component rate allocations. Adjusted cost report data from 1999 will continue to be used for July 1, 2005, through June 30, 2007, support services component rate allocations. Adjusted cost report data from 2005 will be used for July 1, 2007, through June 30, 2009, support services component rate allocations. Effective July 1, 2009, and thereafter for each odd-numbered year beginning July 1st, the support services component rate allocation shall be cost rebased biennially, using the adjusted cost report data for the calendar year two years immediately preceding the rate rebase period, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, 2011, and so forth.

(b) Support services component rate allocations shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act.

(7)(a) Operations component rate allocations shall be established using adjusted cost report data covering at least six months. Adjusted cost report data from 1996 shall be used for October 1, 1998, through June 30, 2001, operations component rate allocations; adjusted cost report data from 1999 shall be used for July 1, 2001, through June 30, 2006, operations component rate allocations. Adjusted cost report data from 2003 will be used for July 1, 2006, through June 30, 2007, operations component rate allocations. Adjusted cost report data from 2005 will be used for July 1, 2007, through June 30, 2009, operations component rate allocations. Effective July 1, 2009, and thereafter for each odd-numbered year beginning July 1st, the operations component rate allocation shall be cost rebased biennially, using the adjusted cost report data for the calendar year two years immediately preceding the rate rebase period, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, 2011, and so forth.

(b) Operations component rate allocations shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. A different economic trends and conditions adjustment factor or factors may be defined in the biennial appropriations act for facilities whose operations component rate is set equal to their adjusted June 30, 2006, rate, as provided in RCW 74.46.521(4).

(8) For July 1, 1998, through September 30, 1998, a facility's property and return on investment component rates shall be the facility's June 30, 1998, property and return on investment component rates, without increase. For October 1, 1998, through June 30, 1999, a facility's property and return on investment component rates shall be rebased utilizing 1997 adjusted cost report data covering at least six months of data.

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

(10) Medicaid contractors shall pay to all facility staff a minimum wage of the greater of the state minimum wage or the federal minimum wage.

(11) The department shall establish in rule procedures, principles, and conditions for determining component rate allocations for facilities in circumstances not directly addressed by this chapter, including but not limited to: The need to prorate inflation for partial-period cost report data, newly constructed facilities, existing facilities entering the medicaid program for the first time or after a period of absence from the program, existing facilities with expanded new bed capacity, existing medicaid facilities following a change of ownership of the nursing facility business, facilities banking beds or converting beds back into service, facilities temporarily reducing the number of set-up beds during a remodel, facilities having less than six months of either resident assessment, cost report data, or both, under the current contractor prior to rate setting, and other circumstances.

(12) The department shall establish in rule procedures, principles, and conditions, including necessary threshold costs, for adjusting rates to reflect capital improvements or new requirements imposed by the department or the federal government. Any such rate adjustments are subject to the provisions of RCW 74.46.421.

(13) Effective July 1, 2001, medicaid rates shall continue to be revised downward in all components, in accordance with department rules, for facilities converting banked beds to active service under chapter 70.38 RCW, by using the facility's increased licensed bed capacity to recalculate minimum occupancy for rate setting. However, for facilities other than essential community providers which bank beds under chapter 70.38 RCW, after May 25, 2001, medicaid rates shall be

revised upward, in accordance with department rules, in direct care, therapy care, support services, and variable return components only, by using the facility's decreased licensed bed capacity to recalculate minimum occupancy for rate setting, but no upward revision shall be made to operations, property, or financing allowance component rates. The direct care component rate allocation shall be adjusted, without using the minimum occupancy assumption, for facilities that convert banked beds to active service, under chapter 70.38 RCW, beginning on July 1, 2006.

(14) 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. 3.** RCW 74.46.511 and 2007 c 508 s 4 are each amended to read as follows:

(1) The therapy care component rate allocation corresponds to the provision of medicaid one-on-one therapy provided by a qualified therapist as defined in this chapter, including therapy supplies and therapy consultation, for one day for one medicaid resident of a nursing facility. The therapy care component rate allocation for October 1, 1998, through June 30, 2001, shall be based on adjusted therapy costs and days from calendar year 1996. The therapy component rate allocation for July 1, 2001, through June 30, 2007, shall be based on adjusted therapy costs and days from calendar year 1999. Effective July 1, 2007, the therapy care component rate allocation shall be based on adjusted therapy costs and days as described in RCW 74.46.431(5). The therapy care component rate shall be adjusted for economic trends and conditions as specified in RCW 74.46.431(5), and shall be determined in accordance with this section. In determining each facility's therapy care component rate allocation, the department shall apply the applicable minimum facility occupancy adjustment before creating the array of facilities' adjusted therapy care costs per adjusted resident day.

(2) In rebasing, as provided in RCW 74.46.431(5)(a), the department shall take from the cost reports of facilities the following reported information:

(a) Direct one-on-one therapy charges for all residents by payer including charges for supplies;

(b) The total units or modules of therapy care for all residents by type of therapy provided, for example, speech or physical. A unit or module of therapy care is considered to be fifteen minutes of one-on-one therapy provided by a qualified therapist or support personnel; and

(c) Therapy consulting expenses for all residents.

(3) The department shall determine for all residents the total cost per unit of therapy for each type of therapy by dividing the total adjusted one-on-one therapy expense for each type by the total units provided for that therapy type.

(4) The department shall divide medicaid nursing facilities in this state into two peer groups:

(a) Those facilities located within urban counties; and

(b) Those located within nonurban counties.

The department shall array the facilities in each peer group from highest to lowest based on their total cost per unit of therapy for each therapy type. The department shall determine the median total cost per unit of therapy for each therapy type and add ten percent of median total cost per unit of therapy. The cost per unit of therapy for each therapy type at a nursing facility shall be the lesser of its cost per unit of therapy for each therapy type or the median total cost per unit plus ten percent for each therapy type for its peer group.

(5) The department shall calculate each nursing facility's therapy care component rate allocation as follows:

(a) To determine the allowable total therapy cost for each therapy type, the allowable cost per unit of therapy for each type of therapy shall be multiplied by the total therapy units for each type of therapy;

(b) The medicaid allowable one-on-one therapy expense shall be calculated taking the allowable total therapy cost for each therapy type times the medicaid percent of total therapy charges for each therapy type;

(c) The medicaid allowable one-on-one therapy expense for each

therapy type shall be divided by total adjusted medicaid days to arrive at the medicaid one-on-one therapy cost per patient day for each therapy type;

(d) The medicaid one-on-one therapy cost per patient day for each therapy type shall be multiplied by total adjusted patient days for all residents to calculate the total allowable one-on-one therapy expense. The lesser of the total allowable therapy consultant expense for the therapy type or a reasonable percentage of allowable therapy consultant expense for each therapy type, as established in rule by the department, shall be added to the total allowable one-on-one therapy expense to determine the allowable therapy cost for each therapy type;

(e) The allowable therapy cost for each therapy type shall be added together, the sum of which shall be the total allowable therapy expense for the nursing facility;

(f) The total allowable therapy expense will be divided by the greater of adjusted total patient days from the cost report on which the therapy expenses were reported, or patient days at eighty-five percent occupancy of licensed beds. The outcome shall be the nursing facility's therapy care component rate allocation.

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

(7) The therapy care component rate shall be suspended for medicaid residents in qualified nursing facilities designated by the department who are receiving therapy paid by the department outside the facility daily rate under RCW 74.46.508(2).

**Sec. 4.** RCW 74.46.515 and 2001 1st sp.s. c 8 s 12 are each amended to read as follows:

(1) The support services component rate allocation corresponds to the provision of food, food preparation, dietary, housekeeping, and laundry services for one resident for one day.

(2) Beginning October 1, 1998, the department shall determine each medicaid nursing facility's support services component rate allocation using cost report data specified by RCW 74.46.431(6).

(3) To determine each facility's support services component rate allocation, the department shall:

(a) Array facilities' adjusted support services costs per adjusted resident day, as determined by dividing each facility's total allowable support services costs by its adjusted resident days for the same report period, increased if necessary to a minimum occupancy provided by RCW 74.46.431(2), for each facility from facilities' cost reports from the applicable report year, for facilities located within urban counties, and for those located within nonurban counties and determine the median adjusted cost for each peer group;

(b) Set each facility's support services component rate at the lower of the facility's per resident day adjusted support services costs from the applicable cost report period or the adjusted median per resident day support services cost for that facility's peer group, either urban counties or nonurban counties, plus 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.

NEW SECTION. **Sec. 5.** The legislature clarifies the enactment of chapter 8, Laws of 2001 1st sp. sess. and intends this act be curative, remedial, and retrospectively applicable to July 1, 1998.

**--- END ---**