

CERTIFICATION OF ENROLLMENT

**HOUSE BILL 2042**

Chapter 3, Laws of 2013

63rd Legislature  
2013 2nd Special Session

NURSING FACILITY MEDICAID PAYMENT SYSTEM

EFFECTIVE DATE: 07/01/13

Passed by the House June 23, 2013  
Yeas 76 Nays 10

FRANK CHOPP

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**Speaker of the House of Representatives**

Passed by the Senate June 23, 2013  
Yeas 41 Nays 7

BRAD OWEN

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**President of the Senate**

Approved June 28, 2013, 3:04 p.m.

JAY INSLEE

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**Governor of the State of Washington**

CERTIFICATE

I, Barbara Baker, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **HOUSE BILL 2042** as passed by the House of Representatives and the Senate on the dates hereon set forth.

BARBARA BAKER

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**Chief Clerk**

FILED

June 28, 2013

**Secretary of State  
State of Washington**

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HOUSE BILL 2042

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Passed Legislature - 2013 2nd Special Session

State of Washington                      63rd Legislature                      2013 Regular Session

By Representatives Cody, Hunter, and Sullivan

Read first time 04/18/13. Referred to Committee on Appropriations.

1            AN ACT Relating to modifying the nursing facility medicaid payment  
2 system by delaying the rebase of certain rate components and extending  
3 certain rate add-ons; amending RCW 74.46.431 and 74.46.501; creating a  
4 new section; providing an 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 2011 1st sp.s. c 7 s 1 are each amended  
7 to read as follows:

8            (1) Nursing facility medicaid payment rate allocations shall be  
9 facility-specific and shall have six components: Direct care, therapy  
10 care, support services, operations, property, and financing allowance.  
11 The department shall establish and adjust each of these components, as  
12 provided in this section and elsewhere in this chapter, for each  
13 medicaid nursing facility in this state.

14            (2) Component rate allocations in therapy care and support services  
15 for all facilities shall be based upon a minimum facility occupancy of  
16 eighty-five percent of licensed beds, regardless of how many beds are  
17 set up or in use. Component rate allocations in operations, property,  
18 and financing allowance for essential community providers shall be  
19 based upon a minimum facility occupancy of eighty-seven percent of

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

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

32 (4)(a) Direct care component rate allocations shall be established  
33 using adjusted cost report data covering at least six months.  
34 Effective July 1, 2009, the direct care component rate allocation shall  
35 be rebased, so that adjusted cost report data for calendar year 2007 is  
36 used for July 1, 2009, through June 30, (~~(2013)~~) 2015. Beginning July  
37 1, (~~(2013)~~) 2015, the direct care component rate allocation shall be  
38 rebased biennially during every odd-numbered year thereafter using

1 adjusted cost report data from two years prior to the rebase period, so  
2 adjusted cost report data for calendar year (~~(2011)~~) 2013 is used for  
3 July 1, (~~(2013)~~) 2015, through June 30, (~~(2015)~~) 2017, and so forth.

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

18 (5)(a) Therapy care component rate allocations shall be established  
19 using adjusted cost report data covering at least six months.  
20 Effective July 1, 2009, the therapy care component rate allocation  
21 shall be cost rebased, so that adjusted cost report data for calendar  
22 year 2007 is used for July 1, 2009, through June 30, (~~(2013)~~) 2015.  
23 Beginning July 1, (~~(2013)~~) 2015, the therapy care component rate  
24 allocation shall be rebased biennially during every odd-numbered year  
25 thereafter using adjusted cost report data from two years prior to the  
26 rebase period, so adjusted cost report data for calendar year (~~(2011)~~)  
27 2013 is used for July 1, (~~(2013)~~) 2015, through June 30, (~~(2015)~~) 2017,  
28 and so forth.

29 (b) Therapy care component rate allocations established in  
30 accordance with this chapter shall be adjusted annually for economic  
31 trends and conditions by a factor or factors defined in the biennial  
32 appropriations act. The economic trends and conditions factor or  
33 factors defined in the biennial appropriations act shall not be  
34 compounded with the economic trends and conditions factor or factors  
35 defined in any other biennial appropriations acts before applying it to  
36 the therapy care component rate allocation established in accordance  
37 with this chapter. When no economic trends and conditions factor or  
38 factors for either fiscal year are defined in a biennial appropriations

1 act, no economic trends and conditions factor or factors defined in any  
2 earlier biennial appropriations act shall be applied solely or  
3 compounded to the therapy care component rate allocation established in  
4 accordance with this chapter.

5 (6)(a) Support services component rate allocations shall be  
6 established using adjusted cost report data covering at least six  
7 months. Effective July 1, 2009, the support services component rate  
8 allocation shall be cost rebased, so that adjusted cost report data for  
9 calendar year 2007 is used for July 1, 2009, through June 30, (~~2013~~)  
10 2015. Beginning July 1, (~~2013~~) 2015, the support services component  
11 rate allocation shall be rebased biennially during every odd-numbered  
12 year thereafter using adjusted cost report data from two years prior to  
13 the rebase period, so adjusted cost report data for calendar year  
14 (~~2011~~) 2013 is used for July 1, (~~2013~~) 2015, through June 30,  
15 (~~2015~~) 2017, and so forth.

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

30 (7)(a) Operations component rate allocations shall be established  
31 using adjusted cost report data covering at least six months.  
32 Effective July 1, 2009, the operations component rate allocation shall  
33 be cost rebased, so that adjusted cost report data for calendar year  
34 2007 is used for July 1, 2009, through June 30, (~~2013~~) 2015.  
35 Beginning July 1, (~~2013~~) 2015, the operations care component rate  
36 allocation shall be rebased biennially during every odd-numbered year  
37 thereafter using adjusted cost report data from two years prior to the

1 rebase period, so adjusted cost report data for calendar year (~~(2011)~~)  
2 2013 is used for July 1, (~~(2013)~~) 2015, through June 30, (~~(2015)~~) 2017,  
3 and so forth.

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

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

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

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

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

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

13 **Sec. 2.** RCW 74.46.501 and 2011 1st sp.s. c 7 s 6 are each amended  
14 to read as follows:

15 (1) From individual case mix weights for the applicable quarter,  
16 the department shall determine two average case mix indexes for each  
17 medicaid nursing facility, one for all residents in the facility, known  
18 as the facility average case mix index, and one for medicaid residents,  
19 known as the medicaid average case mix index.

20 (2)(a) In calculating a facility's two average case mix indexes for  
21 each quarter, the department shall include all residents or medicaid  
22 residents, as applicable, who were physically in the facility during  
23 the quarter in question based on the resident assessment instrument  
24 completed by the facility and the requirements and limitations for the  
25 instrument's completion and transmission (January 1st through March  
26 31st, April 1st through June 30th, July 1st through September 30th, or  
27 October 1st through December 31st).

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

31 (3) Both the facility average and the medicaid average case mix  
32 indexes shall be determined by multiplying the case mix weight of each  
33 resident, or each medicaid resident, as applicable, by the number of  
34 days, as defined in this section and as applicable, the resident was at  
35 each particular case mix classification or group, and then averaging.

36 (4) In determining the number of days a resident is classified into

1 a particular case mix group, the department shall determine a start  
2 date for calculating case mix grouping periods as specified by rule.

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

9 (6)(a) Although the facility average and the medicaid average case  
10 mix indexes shall both be calculated quarterly, the cost-rebasing  
11 period facility average case mix index will be used throughout the  
12 applicable cost-rebasing period in combination with cost report data as  
13 specified by RCW 74.46.431 and 74.46.506, to establish a facility's  
14 allowable cost per case mix unit. To allow for the transition to  
15 minimum data set 3.0 and implementation of resource utilization group  
16 IV for July 1, (~~2011~~) 2013, through June 30, (~~2013~~) 2015, the  
17 department shall calculate rates using the medicaid average case mix  
18 scores effective for January 1, (~~2011~~) 2013, rates adjusted under RCW  
19 74.46.485(1)(a), and the scores shall be increased each six months  
20 during the transition period by one-half of one percent. The July 1,  
21 (~~2013~~) 2015, direct care cost per case mix unit shall be calculated  
22 by utilizing (~~2011~~) 2013 direct care costs, patient days, and  
23 (~~2011~~) 2013 facility average case mix indexes based on the minimum  
24 data set 3.0 resource utilization group IV grouper 57. Otherwise, a  
25 facility's medicaid average case mix index shall be used to update a  
26 nursing facility's direct care component rate semiannually.

27 (b) The facility average case mix index used to establish each  
28 nursing facility's direct care component rate shall be based on an  
29 average of calendar quarters of the facility's average case mix indexes  
30 from the four calendar quarters occurring during the cost report period  
31 used to rebase the direct care component rate allocations as specified  
32 in RCW 74.46.431.

33 (c) The medicaid average case mix index used to update or  
34 recalibrate a nursing facility's direct care component rate  
35 semiannually shall be from the calendar six-month period commencing  
36 nine months prior to the effective date of the semiannual rate. For  
37 example, July 1, 2010, through December 31, 2010, direct care component



1 rates shall utilize case mix averages from the October 1, 2009, through  
2 March 31, 2010, calendar quarters, and so forth.

3 NEW SECTION. **Sec. 3.** (1) For fiscal years 2014 and 2015 and  
4 subject to appropriation, the department of social and health services  
5 shall do a comparative analysis of the facility-based payment rates  
6 calculated on July 1, 2013, using the payment methodology defined in  
7 chapter 74.46 RCW, to the facility-based payment rates in effect June  
8 30, 2010. If the facility-based payment rate calculated on July 1,  
9 2013, is smaller than the facility-based payment rate on June 30, 2010,  
10 the difference shall be provided to the individual nursing facilities  
11 as an add-on payment per medicaid resident day.

12 (2) During the comparative analysis performed in subsection (1) of  
13 this section, if it is found that the direct care rate for any facility  
14 calculated under chapter 74.46 RCW is greater than the direct care rate  
15 in effect on June 30, 2010, then the facility shall receive a ten  
16 percent direct care rate add-on to compensate that facility for taking  
17 on more acute clients than they have in the past.

18 (3) The rate add-ons provided in subsection (2) of this section are  
19 subject to the reconciliation and settlement process provided in RCW  
20 74.46.022(6).

21 NEW SECTION. **Sec. 4.** This act is necessary for the immediate  
22 preservation of the public peace, health, or safety, or support of the  
23 state government and its existing public institutions, and takes effect  
24 July 1, 2013.

Passed by the House June 23, 2013.

Passed by the Senate June 23, 2013.

Approved by the Governor June 28, 2013.

Filed in Office of Secretary of State June 28, 2013.