S-3661.1

SENATE BILL 6306

State of Washington 56th Legislature 2000 Regular Session

By Senators Thibaudeau and Deccio

Read first time . Referred to Committee on .

AN ACT Relating to the nursing facility payment system; amending RCW 74.46.020, 74.46.370, 74.46.421, and 74.46.431; reenacting and amending RCW 74.46.506; and repealing RCW 74.46.908.

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

Sec. 1. RCW 74.46.020 and 1999 c 353 s 1 are each amended to read as follows:

Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Accrual method of accounting" means a method of accounting in which revenues are reported in the period when they are earned, regardless of when they are collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

(2) "Appraisal" means the process of estimating the fair market value or reconstructing the historical cost of an asset acquired in a past period as performed by a professionally designated real estate appraiser with no pecuniary interest in the property to be appraised. It includes a systematic, analytic determination and the recording and analyzing of property facts, rights, investments, and values based on a personal inspection and inventory of the property.

(3) "Arm's-length transaction" means a transaction resulting from good-faith bargaining between a buyer and seller who are not related organizations and have adverse positions in the market place. Sales or exchanges of nursing home facilities among two or more parties in which all parties subsequently continue to own one or more of the facilities involved in the transactions shall not be considered as arm's-length transactions for purposes of this chapter. Sale of a nursing home facility which is subsequently leased back to the seller within five years of the date of sale shall not be considered as an arm's-length transaction for purposes of this chapter.

(4) "Assets" means economic resources of the contractor, recognized and measured in conformity with generally accepted accounting principles.

(5) "Audit" or "department audit" means an examination of the records of a nursing facility participating in the medicaid payment system, including but not limited to: The contractor's financial and statistical records, cost reports and all supporting documentation and schedules, receivables, and resident trust funds, to be performed as deemed necessary by the department and according to department rule.

(6) "Bad debts" means amounts considered to be uncollectible from accounts and notes receivable.

(7) "Beneficial owner" means:

(a) Any person who, directly or indirectly, through any contract, arrangement, understanding, relationship, or otherwise has or shares:

(i) Voting power which includes the power to vote, or to direct the voting of such ownership interest; and/or

(ii) Investment power which includes the power to dispose, or to direct the disposition of such ownership interest;

(b) Any person who, directly or indirectly, creates or uses a trust, proxy, power of attorney, pooling arrangement, or any other contract, arrangement, or device with the purpose or effect of divesting himself or herself of beneficial ownership of an ownership interest or preventing the vesting of such beneficial ownership as part of a plan or scheme to evade the reporting requirements of this chapter;

(c) Any person who, subject to (b) of this subsection, has the right to acquire beneficial ownership of such ownership interest within sixty days, including but not limited to any right to acquire:

(i) Through the exercise of any option, warrant, or right;

(ii) Through the conversion of an ownership interest;

(iii) Pursuant to the power to revoke a trust, discretionary account, or similar arrangement; or

(iv) Pursuant to the automatic termination of a trust, discretionary account, or similar arrangement;

except that, any person who acquires an ownership interest or power specified in (c)(i), (ii), or (iii) of this subsection with the purpose or effect of changing or influencing the control of the contractor, or in connection with or as a participant in any transaction having such purpose or effect, immediately upon such acquisition shall be deemed to be the beneficial owner of the ownership interest which may be acquired through the exercise or conversion of such ownership interest or power;

(d) Any person who in the ordinary course of business is a pledgee of ownership interest under a written pledge agreement shall not be deemed to be the beneficial owner of such pledged ownership interest until the pledgee has taken all formal steps necessary which are required to declare a default and determines that the power to vote or to direct the vote or to dispose or to direct the disposition of such pledged ownership interest will be exercised; except that:

(i) The pledgee agreement is bona fide and was not entered into with the purpose nor with the effect of changing or influencing the control of the contractor, nor in connection with any transaction having such purpose or effect, including persons meeting the conditions set forth in (b) of this subsection; and

(ii) The pledgee agreement, prior to default, does not grant to the pledgee:

(A) The power to vote or to direct the vote of the pledged ownership interest; or

(B) The power to dispose or direct the disposition of the pledged ownership interest, other than the grant of such power(s) pursuant to a pledge agreement under which credit is extended and in which the pledgee is a broker or dealer.

(8) ((~~"Capital portion of the rate" means the sum of the property and financing allowance rate allocations, as established in part E of this chapter.~~

~~(9)~~)) "Capitalization" means the recording of an expenditure as an asset.

((~~(10)~~)) (9) "Case mix" means a measure of the intensity of care and services needed by the residents of a nursing facility or a group of residents in the facility.

((~~(11)~~)) (10) "Case mix index" means a number representing the average case mix of a nursing facility.

((~~(12)~~)) (11) "Case mix weight" means a numeric score that identifies the relative resources used by a particular group of a nursing facility's residents.

((~~(13)~~)) (12) "Contractor" means a person or entity licensed under chapter 18.51 RCW to operate a medicare and medicaid certified nursing facility, responsible for operational decisions, and contracting with the department to provide services to medicaid recipients residing in the facility.

((~~(14)~~)) (13) "Default case" means no initial assessment has been completed for a resident and transmitted to the department by the cut-off date, or an assessment is otherwise past due for the resident, under state and federal requirements.

((~~(15)~~)) (14) "Department" means the department of social and health services (DSHS) and its employees.

((~~(16)~~)) (15) "Depreciation" means the systematic distribution of the cost or other basis of tangible assets, less salvage, over the estimated useful life of the assets.

((~~(17)~~)) (16) "Direct care" means nursing care and related care provided to nursing facility residents. Therapy care shall not be considered part of direct care.

((~~(18)~~)) (17) "Direct care supplies" means medical, pharmaceutical, and other supplies required for the direct care of a nursing facility's residents.

((~~(19)~~)) (18) "Entity" means an individual, partnership, corporation, limited liability company, or any other association of individuals capable of entering enforceable contracts.

((~~(20)~~)) (19) "Equity" means the net book value of all tangible and intangible assets less the recorded value of all liabilities, as recognized and measured in conformity with generally accepted accounting principles.

((~~(21)~~)) (20) "Facility" or "nursing facility" means a nursing home licensed in accordance with chapter 18.51 RCW, excepting nursing homes certified as institutions for mental diseases, or that portion of a multiservice facility licensed as a nursing home, or that portion of a

hospital licensed in accordance with chapter 70.41 RCW which operates as a nursing home.

((~~(22)~~)) (21) "Fair market value" means the replacement cost of an asset less observed physical depreciation on the date for which the market value is being determined.

((~~(23)~~)) (22) "Financial statements" means statements prepared and presented in conformity with generally accepted accounting principles including, but not limited to, balance sheet, statement of operations, statement of changes in financial position, and related notes.

((~~(24)~~)) (23) "Generally accepted accounting principles" means accounting principles approved by the financial accounting standards board (FASB).

((~~(25)~~)) (24) "Goodwill" means the excess of the price paid for a nursing facility business over the fair market value of all net identifiable tangible and intangible assets acquired, as measured in accordance with generally accepted accounting principles.

((~~(26)~~)) (25) "Grouper" means a computer software product that groups individual nursing facility residents into case mix classification groups based on specific resident assessment data and computer logic.

((~~(27)~~)) (26) "Historical cost" means the actual cost incurred in acquiring and preparing an asset for use, including feasibility studies, architect’s fees, and engineering studies.

((~~(28)~~)) (27) "Imprest fund" means a fund which is regularly replenished in exactly the amount expended from it.

((~~(29)~~)) (28) "Joint facility costs" means any costs which represent resources which benefit more than one facility, or one facility and any other entity.

((~~(30)~~)) (29) "Lease agreement" means a contract between two parties for the possession and use of real or personal property or assets for a specified period of time in exchange for specified periodic payments. Elimination (due to any cause other than death or divorce) or addition of any party to the contract, expiration, or modification of any lease term in effect on January 1, 1980, or termination of the lease by either party by any means shall constitute a termination of the lease agreement. An extension or renewal of a lease agreement, whether or not pursuant to a renewal provision in the lease agreement, shall be considered a new lease agreement. A strictly formal change in the lease agreement which modifies the method,

frequency, or manner in which the lease payments are made, but does not increase the total lease payment obligation of the lessee, shall not be considered modification of a lease term.

((~~(31)~~)) (30) "Medical care program" or "medicaid program" means medical assistance, including nursing care, provided under RCW 74.09.500 or authorized state medical care services.

((~~(32)~~)) (31) "Medical care recipient," "medicaid recipient," or "recipient" means an individual determined eligible by the department for the services provided under chapter 74.09 RCW.

((~~(33)~~)) (32) "Minimum data set" means the overall data component of the resident assessment instrument, indicating the strengths, needs, and preferences of an individual nursing facility resident.

((~~(34)~~)) (33) "Net book value" means the historical cost of an asset less accumulated depreciation.

((~~(35)~~)) (34) "Net invested funds" means the net book value of tangible fixed assets employed by a contractor to provide services under the medical care program, including land, buildings, and equipment as recognized and measured in conformity with generally accepted accounting principles, plus an allowance of working capital which shall be five percent of the product of the per-patient-day rate multiplied by the prior calendar year reported total patient days of each contractor.

((~~(36) "Noncapital portion of the rate" means the sum of the direct care, therapy care, operations, support services, and variable return rate allocations, as established in part E of this chapter.~~

~~(37)~~)) (35) "Operating lease" means a lease under which rental or lease expenses are included in current expenses in accordance with generally accepted accounting principles.

((~~(38)~~)) (36) "Owner" means a sole proprietor, general or limited partners, members of a limited liability company, and beneficial interest holders of five percent or more of a corporation's outstanding stock.

((~~(39)~~)) (37) "Ownership interest" means all interests beneficially owned by a person, calculated in the aggregate, regardless of the form which such beneficial ownership takes.

((~~(40)~~)) (38) "Patient day" or "resident day" means a calendar day of care provided to a nursing facility resident, regardless of payment source, which will include the day of admission and exclude the day of discharge; except that, when admission and discharge occur on the same

day, one day of care shall be deemed to exist. A "medicaid day" or "recipient day" means a calendar day of care provided to a medicaid recipient determined eligible by the department for services provided under chapter 74.09 RCW, subject to the same conditions regarding admission and discharge applicable to a patient day or resident day of care.

((~~(41)~~)) (39) "Professionally designated real estate appraiser" means an individual who is regularly engaged in the business of providing real estate valuation services for a fee, and who is deemed qualified by a nationally recognized real estate appraisal educational organization on the basis of extensive practical appraisal experience, including the writing of real estate valuation reports as well as the passing of written examinations on valuation practice and theory, and who by virtue of membership in such organization is required to subscribe and adhere to certain standards of professional practice as such organization prescribes.

((~~(42)~~)) (40) "Qualified therapist" means:

(a) A mental health professional as defined by chapter 71.05 RCW;

(b) A mental retardation professional who is a therapist approved by the department who has had specialized training or one year's experience in treating or working with the mentally retarded or developmentally disabled;

(c) A speech pathologist who is eligible for a certificate of clinical competence in speech pathology or who has the equivalent education and clinical experience;

(d) A physical therapist as defined by chapter 18.74 RCW;

(e) An occupational therapist who is a graduate of a program in occupational therapy, or who has the equivalent of such education or training; and

(f) A respiratory care practitioner certified under chapter 18.89 RCW.

((~~(43)~~)) (41) "Rate" or "rate allocation" means the medicaid per-patient-day payment amount for medicaid patients calculated in accordance with the allocation methodology set forth in part E of this chapter.

((~~(44)~~)) (42) "Real property," whether leased or owned by the contractor, means the building, allowable land, land improvements, and building improvements associated with a nursing facility.

((~~(45)~~)) (43) "Rebased rate" or "cost-rebased rate" means a facility-specific component rate assigned to a nursing facility for a particular rate period established on desk-reviewed, adjusted costs reported for that facility covering at least six months of a prior calendar year designated as a year to be used for cost-rebasing payment rate allocations under the provisions of this chapter.

((~~(46)~~)) (44) "Records" means those data supporting all financial statements and cost reports including, but not limited to, all general and subsidiary ledgers, books of original entry, and transaction documentation, however such data are maintained.

((~~(47)~~)) (45) "Related organization" means an entity which is under common ownership and/or control with, or has control of, or is controlled by, the contractor.

(a) "Common ownership" exists when an entity is the beneficial owner of five percent or more ownership interest in the contractor and any other entity.

(b) "Control" exists where an entity has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution, whether or not it is legally enforceable and however it is exercisable or exercised.

((~~(48)~~)) (46) "Related care" means only those services that are directly related to providing direct care to nursing facility residents. These services include, but are not limited to, nursing direction and supervision, medical direction, medical records, pharmacy services, activities, and social services.

((~~(49)~~)) (47) "Resident assessment instrument," including federally approved modifications for use in this state, means a federally mandated, comprehensive nursing facility resident care planning and assessment tool, consisting of the minimum data set and resident assessment protocols.

((~~(50)~~)) (48) "Resident assessment protocols" means those components of the resident assessment instrument that use the minimum data set to trigger or flag a resident’s potential problems and risk areas.

((~~(51)~~)) (49) "Resource utilization groups" means a case mix classification system that identifies relative resources needed to care for an individual nursing facility resident.

((~~(52)~~)) (50) "Restricted fund" means those funds the principal and/or income of which is limited by agreement with or direction of the donor to a specific purpose.

((~~(53)~~)) (51) "Secretary" means the secretary of the department of social and health services.

((~~(54)~~)) (52) "Support services" means food, food preparation, dietary, housekeeping, and laundry services provided to nursing facility residents.

((~~(55)~~)) (53) "Therapy care" means those services required by a nursing facility resident's comprehensive assessment and plan of care, that are provided by qualified therapists, or support personnel under their supervision, including related costs as designated by the department.

((~~(56)~~)) (54) "Title XIX" or "medicaid" means the 1965 amendments to the social security act, P.L. 89-07, as amended and the medicaid program administered by the department.

Sec. 2. RCW 74.46.370 and 1999 c 353 s 14 are each amended to read as follows:

(1) Except for new buildings, major remodels, and major repair projects, as defined in subsection (2) of this section, the contractor shall use lives which reflect the estimated actual useful life of the asset and which shall be no shorter than guideline lives as established by the department. Lives shall be measured from the date on which the assets were first used in the medical care program or from the date of the most recent arm's-length acquisition of the asset, whichever is more recent. In cases where RCW 74.46.360(6)(a) does apply, the shortest life that may be used for buildings is the remaining useful life under the prior contract. In all cases, lives shall be extended to reflect periods, if any, when assets were not used in or as a facility.

(2) Effective July 1, 1997, for asset acquisitions and new facilities, major remodels, and major repair projects that begin operations on or after July 1, 1997, the department shall use the most current edition of Estimated Useful Lives of Depreciable Hospital Assets, or as it may be renamed, published by the American Hospital Publishing, Inc., an American hospital association company, for determining the useful life of new buildings, major remodels, and major repair projects, however, the shortest life that may be used for new

buildings receiving certificate of need approval or certificate of need exemptions under chapter 70.38 RCW on or after July 1, 1999, is ((~~forty~~)) thirty years. New buildings, major remodels, and major repair projects include those projects that meet or exceed the expenditure minimum established by the department of health pursuant to chapter 70.38 RCW.

(3) Building improvements, other than major remodels and major repairs, shall be depreciated over the remaining useful life of the building, as modified by the improvement.

(4) Improvements to leased property which are the responsibility of the contractor under the terms of the lease shall be depreciated over the useful life of the improvement.

(5) A contractor may change the estimate of an asset's useful life to a longer life for purposes of depreciation.

(6) For new or replacement building construction or for major renovations, either of which receives certificate of need approval or certificate of need exemption under chapter 70.38 RCW on or after July 1, 1999, the number of years used to depreciate fixed equipment shall be the same number of years as the life of the building to which it is affixed.

Sec. 3. RCW 74.46.421 and 1999 c 353 s 3 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 state-wide average payment rate to nursing facilities is less than or equal to the state-wide average payment rate specified in the biennial appropriations act.

(c) The state-wide average payment rate specified in the biennial appropriations act shall be determined by applying the nursing facility medicaid payment rate methodologies described in this chapter, allowing a reasonable growth rate in the property component rate allocation, and

allowing a reasonable adjustment to the facility average case mix, as needed.

(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 state-wide average payment rate to exceed the state-wide average payment rate specified in the biennial appropriations act.

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

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

(((~~(5)(a) The state-wide average payment rate for the noncapital portion of the rate for any state fiscal year under the nursing facility payment system, weighted by patient days, shall not exceed the annual state-wide weighted average nursing facility payment rate for the noncapital portion of the rate identified for that fiscal year in the biennial appropriations act.~~

~~(b) If the department determines that the weighted average nursing facility payment rate for the noncapital portion of the rate calculated in accordance with this chapter is likely to exceed the weighted average nursing facility payment rate for the noncapital portion of the rate identified in the biennial appropriations act, then the department shall adjust all nursing facility direct care, therapy care, support services, operations, and variable return payment rates proportional to the amount by which the weighted average rate allocations would~~

~~otherwise exceed the budgeted noncapital portion of the rate amount. Any such adjustments shall only be made prospectively, not retrospectively, and shall be applied proportionately to each direct care, therapy care, support services, operations, and variable return rate allocation for each facility.~~))

(c) Any rate adjustments made under (b) of this subsection that are in excess of the amount necessary to comply with (a) of this subsection shall be refunded to each nursing facility.

Sec. 4. RCW 74.46.431 and 1999 c 353 s 4 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) All component rate allocations 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.

(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, 2004, direct care component rate allocations.

(b) Beginning July 1, 2000, and for all subsequent July 1st calendar year periods, the nonrebased direct care component rate allocations, based on ((~~1996~~)) the rebase year cost report data, shall be adjusted ((~~annually~~)) for economic trends and conditions by ((~~a factor or factors defined in the biennial appropriations act~~)) the change in the nursing home input price index, without capital costs,

published by the health care financing administration of the department of health and human services (HCFA index). The period to be used to measure the HCFA index increase or decrease shall be the calendar year immediately preceding the July 1st nonrebased rate period. ((~~A different~~)) An economic trends and conditions adjustment factor ((~~or factors may be defined in the biennial appropriations act~~)) of two percent shall be used to adjust the direct care component rate allocations 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)(k).

(c) Beginning July 1, 2001, the 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~~)) the change in the HCFA index for the calendar year that immediately precedes the July 1, 2001, rate period, multiplied by a factor of 2.0. ((~~A different~~)) An economic trends and conditions adjustment factor ((~~or factors may be defined in the biennial appropriations act~~)) of two percent shall be used to adjust the direct care component rate allocations 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)(k).

(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, 2004, therapy care component rate allocations.

(b) Beginning July 1, 2000, and for all subsequent July 1st calendar year periods, the nonrebased therapy care component rate allocations, based on the rebase year cost report data, shall be adjusted ((~~annually~~)) for economic trends and conditions by ((~~a factor or factors defined in the biennial appropriations act~~)) the change in the nursing home input price index, without capital costs, published by the health care financing administration of the department of health and human services (HCFA index). The period to be used to measure the HCFA index increase or decrease shall be the calendar year immediately preceding the July 1st nonrebased rate period.

(c) Beginning July 1, 2001, the therapy care component rate allocations, based on 1999 cost report data, shall be adjusted for

economic trends and conditions by the change in the HCFA index for the calendar year that immediately precedes the July 1, 2001, rate period, multiplied by a factor of 2.0.

(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, 2004, support services component rate allocations.

(b) Beginning July 1, 2000, and for all subsequent July 1st calendar year periods, the nonrebased support services component rate allocations, based on the rebase year cost report data, shall be adjusted ((~~annually~~)) for economic trends and conditions by ((~~a factor or factors defined in the biennial appropriations act~~)) the change in the nursing home input price index, without capital costs, published by the health care financing administration of the department of health and human services (HCFA index). The period to be used to measure the HCFA index increase or decrease shall be the calendar year immediately preceding the July 1st nonrebased rate period.

(c) Beginning July 1, 2001, support services component rate allocations, based on 1999 cost report data, shall be adjusted for economic trends and conditions by the change in the HCFA index for the calendar year that immediately precedes the July 1, 2001, rate period, multiplied by a factor of 2.0.

(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, 2004, operations component rate allocations.

(b) Beginning July 1, 2000, and for all subsequent July 1st calendar year periods, the nonrebased operations component rate allocations, based on the rebase year cost report data, shall be adjusted ((~~annually~~)) for economic trends and conditions by ((~~a factor or factors defined in the biennial appropriations act~~)) the change in the nursing home input price index, without capital costs, published by the health care financing administration of the department of health and human services (HCFA index). The period to be used to measure the

HCFA index increase or decrease shall be the calendar year immediately preceding the July 1st nonrebased rate period.

(c) Beginning July 1, 2001, the operations component rate allocations, based on 1999 cost report data, shall be adjusted for economic trends and conditions by the change in the HCFA index for the calendar year that immediately precedes the July 1, 2001, rate period, multiplied by a factor of 2.0.

(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)~~)) (9) Medicaid contractors shall pay to all facility staff a minimum wage of the greater of five dollars and fifteen cents per hour or the federal minimum wage.

((~~(11)~~)) (10) 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 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)~~)) (11) 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.

Sec. 5. RCW 74.46.506 and 1999 c 353 s 5 and 1999 c 181 s 1 are each reenacted and amended to read as follows:

(1) The direct care component rate allocation corresponds to the provision of nursing care for one resident of a nursing facility for one day, including direct care supplies. Therapy services and supplies, which correspond to the therapy care component rate, shall be excluded. The direct care component rate includes elements of case mix determined consistent with the principles of this section and other applicable provisions of this chapter.

(2) Beginning October 1, 1998, the department shall determine and update quarterly for each nursing facility serving medicaid residents a facility-specific per-resident day direct care component rate allocation, to be effective on the first day of each calendar quarter. In determining direct care component rates the department shall utilize, as specified in this section, minimum data set resident assessment data for each resident of the facility, as transmitted to, and if necessary corrected by, the department in the resident assessment instrument format approved by federal authorities for use in this state.

(3) The department may question the accuracy of assessment data for any resident and utilize corrected or substitute information, however derived, in determining direct care component rates. The department is authorized to impose civil fines and to take adverse rate actions against a contractor, as specified by the department in rule, in order to obtain compliance with resident assessment and data transmission requirements and to ensure accuracy.

(4) Cost report data used in setting direct care component rate allocations shall be 1996 and 1999, for rate periods as specified in RCW 74.46.431(4)(a).

(5) Beginning October 1, 1998, the department shall rebase each nursing facility's direct care 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, consistent with the following:

(a) Reduce 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, increased if necessary to a minimum occupancy of eighty-five percent; that is, the greater of actual or imputed occupancy at eighty-five percent of licensed beds, to derive the facility's allowable direct care cost per resident day;

(c) Adjust the facility's per resident day direct care cost by the applicable factor specified in RCW 74.46.431(4) (b) and (c) to derive its adjusted allowable direct care cost per resident day;

(d) 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(7)(b) to derive the facility's allowable direct care cost per case mix unit;

(e) Divide nursing facilities into two peer groups: Those located in metropolitan statistical areas as determined and defined by the United States office of management and budget or other appropriate agency or office of the federal government, and those not located in a metropolitan statistical area;

(f) Array separately the allowable direct care cost per case mix unit for all metropolitan statistical area and for all nonmetropolitan statistical area facilities, and determine the median allowable direct care cost per case mix unit for each peer group;

(g) Except as provided in (k) of this subsection, from October 1, 1998, through June 30, 2000, determine each facility's quarterly direct care component rate as follows:

(i) Any facility whose allowable cost per case mix unit is less than eighty-five percent of the facility's peer group median established under (f) of this subsection shall be assigned a cost per case mix unit equal to eighty-five percent of the facility's 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 quarter specified in RCW 74.46.501(7)(c);

(ii) Any facility whose allowable cost per case mix unit is greater than one hundred fifteen percent of the peer group median established under (f) of this subsection shall be assigned a cost per case mix unit equal to one hundred fifteen 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 quarter specified in RCW 74.46.501(7)(c);

(iii) Any facility whose allowable cost per case mix unit is between eighty-five and one hundred fifteen percent of the peer group median established under (f) of this subsection shall have a direct care component rate allocation equal to the facility's allowable cost per case mix unit multiplied by that facility's medicaid average case mix index from the applicable quarter specified in RCW 74.46.501(7)(c);

(h) Except as provided in (k) of this subsection, from July 1, 2000, through June 30, 2002, determine each facility's quarterly direct care component rate as follows:

(i) Any facility whose allowable cost per case mix unit is less than ninety percent of the facility's peer group median established under (f) of this subsection shall be assigned a cost per case mix unit equal to ninety percent of the facility's 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 quarter specified in RCW 74.46.501(7)(c);

(ii) Any facility whose allowable cost per case mix unit is greater than one hundred ten percent of the peer group median established under (f) of this subsection shall be assigned a cost per case mix unit equal to one hundred ten 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 quarter specified in RCW 74.46.501(7)(c);

(iii) Any facility whose allowable cost per case mix unit is between ninety and one hundred ten percent of the peer group median established under (f) of this subsection shall have a direct care component rate allocation equal to the facility's allowable cost per case mix unit multiplied by that facility's medicaid average case mix index from the applicable quarter specified in RCW 74.46.501(7)(c);

(i) From July 1, 2002, through June 30, 2004, determine each facility's quarterly direct care component rate as follows:

(i) Any facility whose allowable cost per case mix unit is less than ninety-five percent of the facility's peer group median

established under (f) of this subsection shall be assigned a cost per case mix unit equal to ninety-five percent of the facility's 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 quarter specified in RCW 74.46.501(7)(c);

(ii) Any facility whose allowable cost per case mix unit is greater than one hundred five percent of the peer group median established under (f) of this subsection shall be assigned a cost per case mix unit equal to one hundred five 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 quarter specified in RCW 74.46.501(7)(c);

(iii) Any facility whose allowable cost per case mix unit is between ninety-five and one hundred five percent of the peer group median established under (f) of this subsection shall have a direct care component rate allocation equal to the facility's allowable cost per case mix unit multiplied by that facility's medicaid average case mix index from the applicable quarter specified in RCW 74.46.501(7)(c);

(j) Beginning July 1, 2004, determine each facility's quarterly direct care component rate by multiplying the facility's peer group median allowable direct care cost per case mix unit by that facility's medicaid average case mix index from the applicable quarter as specified in RCW 74.46.501(7)(c).

(k)(i) Between October 1, 1998, and June 30, 2000, the department shall compare each facility's direct care component rate allocation calculated under (g) of this subsection with the facility's nursing services component rate in effect on September 30, 1998, less therapy costs, plus any exceptional care offsets as reported on the cost report, adjusted for economic trends and conditions as provided in RCW 74.46.431. A facility shall receive the higher of the two rates;

(ii) Between July 1, 2000, and June 30, 2002, the department shall compare each facility's direct care component rate allocation calculated under (h) of this subsection with the facility's direct care component rate in effect on June 30, 2000, adjusted for economic trends and conditions as provided in RCW 74.46.431. A facility shall receive the higher of the two rates.

(6) The direct 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) Payments resulting from increases in direct care component rates, granted under authority of RCW 74.46.508(1) for a facility's exceptional care residents, shall be offset against the facility's examined, allowable direct care costs, for each report year or partial period such increases are paid. Such reductions in allowable direct care costs shall be for rate setting, settlement, and other purposes deemed appropriate by the department.

NEW SECTION. **Sec. 6.** RCW 74.46.908 (Repealer) and 1999 c 353 s 17 are each repealed.

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