
HOUSE BILL 1379

State of Washington

57th Legislature

2001 Regular Session

By Representatives Cody, H. Sommers, Benson and Kagi; by request of Department of Social and Health Services

Read first time 01/24/2001. Referred to Committee on Health Care.

1 AN ACT Relating to adjusting nursing home payments to enhance
2 direct care; amending RCW 74.46.165, 74.46.410, 74.46.431, 74.46.433,
3 74.46.435, 74.46.437, 74.46.501, 74.46.515, 74.46.521, and 74.46.711;
4 reenacting and amending RCW 74.46.506 and 74.46.511; adding a new
5 section to chapter 74.46 RCW; creating a new section; repealing RCW
6 74.46.280 and 74.46.908; providing effective dates; and declaring an
7 emergency.

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

9 **Sec. 1.** RCW 74.46.165 and 1998 c 322 s 10 are each amended to read
10 as follows:

11 (1) Contractors shall be required to submit with each annual
12 nursing facility cost report a proposed settlement report showing
13 underspending or overspending in each component rate during the cost
14 report year on a per-resident day basis. The department shall accept
15 or reject the proposed settlement report, explain any adjustments, and
16 issue a revised settlement report if needed.

17 (2) Contractors shall not be required to refund payments made in
18 the operations, variable return, property, and (~~return on investment~~)

1 financing allowance component rates in excess of the adjusted costs of
2 providing services corresponding to these components.

3 (3) The facility will return to the department any overpayment
4 amounts in each of the direct care, therapy care, and support services
5 rate components that the department identifies following the audit and
6 settlement procedures as described in this chapter, provided that the
7 contractor may retain any overpayment that does not exceed 1.0% of the
8 facility's direct care, therapy care, and support services component
9 rate. However, no overpayments may be retained in a cost center to
10 which savings have been shifted to cover a deficit, as provided in
11 subsection (4) of this section. Facilities that are not in substantial
12 compliance for more than ninety days, and facilities that provide
13 substandard quality of care at any time, during the period for which
14 settlement is being calculated, will not be allowed to retain any
15 amount of overpayment in the facility's direct care, therapy care, and
16 support services component rate. The terms "not in substantial
17 compliance" and "substandard quality of care" shall be defined by
18 federal survey regulations.

19 (4) Determination of unused rate funds, including the amounts of
20 direct care, therapy care, and support services to be recovered, shall
21 be done separately for each component rate, and, except as otherwise
22 provided in this subsection, neither costs nor rate payments shall be
23 shifted from one component rate or corresponding service area to
24 another in determining the degree of underspending or recovery, if any.
25 (~~However,~~) In computing a preliminary or final settlement, savings in
26 the support services cost center (~~may~~) shall be shifted to cover a
27 deficit in the direct care or therapy cost centers up to the amount of
28 any savings, but no more than twenty percent of the support services
29 component rate may be shifted. Savings in direct care and therapy care
30 may be shifted between these two cost centers up to the amount of
31 savings in each, regardless of the percentage of either component rate
32 shifted. Contractor-retained overpayments up to one percent of direct
33 care, therapy care, and support services rate components, as authorized
34 in subsection (3) of this section, shall be calculated and applied
35 after all shifting is completed. (~~Not more than twenty percent of the~~
36 rate in a cost center may be shifted.)

37 (5) Total and component payment rates assigned to a nursing
38 facility, as calculated and revised, if needed, under the provisions of
39 this chapter and those rules as the department may adopt, shall

1 represent the maximum payment for nursing facility services rendered to
2 medicaid recipients for the period the rates are in effect. No
3 increase in payment to a contractor shall result from spending above
4 the total payment rate or in any rate component.

5 (6) RCW 74.46.150 through 74.46.180, and rules adopted by the
6 department prior to July 1, 1998, shall continue to govern the medicaid
7 settlement process for periods prior to October 1, 1998, as if these
8 statutes and rules remained in full force and effect.

9 (7) For calendar year 1998, the department shall calculate split
10 settlements covering January 1, 1998, through September 30, 1998, and
11 October 1, 1998, through December 31, 1998. For the period beginning
12 October 1, 1998, rules specified in this chapter shall apply. The
13 department shall, by rule, determine the division of calendar year 1998
14 adjusted costs for settlement purposes.

15 **Sec. 2.** RCW 74.46.410 and 1998 c 322 s 17 are each amended to read
16 as follows:

17 (1) Costs will be unallowable if they are not documented,
18 necessary, ordinary, and related to the provision of care services to
19 authorized patients.

20 (2) Unallowable costs include, but are not limited to, the
21 following:

22 (a) Costs of items or services not covered by the medical care
23 program. Costs of such items or services will be unallowable even if
24 they are indirectly reimbursed by the department as the result of an
25 authorized reduction in patient contribution;

26 (b) Costs of services and items provided to recipients which are
27 covered by the department's medical care program but not included in
28 the medicaid per-resident day payment rate established by the
29 department under this chapter;

30 (c) Costs associated with a capital expenditure subject to section
31 1122 approval (part 100, Title 42 C.F.R.) if the department found it
32 was not consistent with applicable standards, criteria, or plans. If
33 the department was not given timely notice of a proposed capital
34 expenditure, all associated costs will be unallowable up to the date
35 they are determined to be reimbursable under applicable federal
36 regulations;

37 (d) Costs associated with a construction or acquisition project
38 requiring certificate of need approval, or exemption from the

1 requirements for certificate of need for the replacement of existing
2 nursing home beds, pursuant to chapter 70.38 RCW if such approval or
3 exemption was not obtained;

4 (e) Interest costs other than those provided by RCW 74.46.290 on
5 and after January 1, 1985;

6 (f) Salaries or other compensation of owners, officers, directors,
7 stockholders, partners, principals, participants, and others associated
8 with the contractor or its home office, including all board of
9 directors' fees and, in the case of publicly operated facilities,
10 commissioners' fees, for any purpose, except reasonable compensation
11 paid for service related to patient care;

12 (g) Costs in excess of limits or in violation of principles set
13 forth in this chapter;

14 (h) Costs resulting from transactions or the application of
15 accounting methods which circumvent the principles of the payment
16 system set forth in this chapter;

17 (i) Costs applicable to services, facilities, and supplies
18 furnished by a related organization in excess of the lower of the cost
19 to the related organization or the price of comparable services,
20 facilities, or supplies purchased elsewhere;

21 (j) ~~Bad debts of Title XIX or non-Title XIX recipients((.---Bad~~
22 ~~debts of Title XIX recipients are allowable if the debt is related to~~
23 ~~covered services, it arises from the recipient's required contribution~~
24 ~~toward the cost of care, the provider can establish that reasonable~~
25 ~~collection efforts were made, the debt was actually uncollectible when~~
26 ~~claimed as worthless, and sound business judgment established that~~
27 ~~there was no likelihood of recovery at any time in the future))~~);

28 (k) Charity and courtesy allowances;

29 (l) Cash, assessments, or other contributions, excluding dues, to
30 charitable organizations, professional organizations, trade
31 associations, or political parties, and costs incurred to improve
32 community or public relations;

33 (m) Vending machine expenses;

34 (n) Expenses for barber or beautician services not included in
35 routine care;

36 (o) Funeral and burial expenses;

37 (p) Costs of gift shop operations and inventory;

1 (q) Personal items such as cosmetics, smoking materials, newspapers
2 and magazines, and clothing, except those used in patient activity
3 programs;

4 (r) Fund-raising expenses, except those directly related to the
5 patient activity program;

6 (s) Penalties and fines;

7 (t) Expenses related to telephones, (~~televisions~~) radios, and
8 similar appliances in patients' private accommodations;

9 (u) Federal, state, and other income taxes;

10 (v) Costs of special care services except where authorized by the
11 department;

12 (w) Expenses of an employee benefit not in fact made available to
13 all employees on an equal or fair basis, for example, key-man insurance
14 and other insurance or retirement plans;

15 (x) Expenses of profit-sharing plans;

16 (y) Expenses related to the purchase and/or use of private or
17 commercial airplanes which are in excess of what a prudent contractor
18 would expend for the ordinary and economic provision of such a
19 transportation need related to patient care;

20 (z) Personal expenses and allowances of owners or relatives;

21 (aa) All expenses of maintaining professional licenses or
22 membership in professional organizations;

23 (bb) Costs related to agreements not to compete;

24 (cc) Amortization of goodwill, lease acquisition, or any other
25 intangible asset, whether related to resident care or not, and whether
26 recognized under generally accepted accounting principles or not;

27 (dd) Expenses related to vehicles which are in excess of what a
28 prudent contractor would expend for the ordinary and economic provision
29 of transportation needs related to patient care;

30 (ee) Legal and consultant fees in connection with a fair hearing
31 against the department where a decision is rendered in favor of the
32 department or where otherwise the determination of the department
33 stands;

34 (ff) Legal and consultant fees of a contractor or contractors in
35 connection with a lawsuit against the department;

36 (gg) Lease acquisition costs, goodwill, the cost of bed rights, or
37 any other intangible assets;

38 (hh) All rental or lease costs other than those provided in RCW
39 74.46.300 on and after January 1, 1985;

1 (ii) Postsurvey charges incurred by the facility as a result of
2 subsequent inspections under RCW 18.51.050 which occur beyond the first
3 postsurvey visit during the certification survey calendar year;

4 (jj) Compensation paid for any purchased nursing care services,
5 including registered nurse, licensed practical nurse, and nurse
6 assistant services, obtained through service contract arrangement in
7 excess of the amount of compensation paid for such hours of nursing
8 care service had they been paid at the average hourly wage, including
9 related taxes and benefits, for in-house nursing care staff of like
10 classification at the same nursing facility, as reported in the most
11 recent cost report period;

12 (kk) For all partial or whole rate periods after July 17, 1984,
13 costs of land and depreciable assets that cannot be reimbursed under
14 the Deficit Reduction Act of 1984 and implementing state statutory and
15 regulatory provisions;

16 (ll) Costs reported by the contractor for a prior period to the
17 extent such costs, due to statutory exemption, will not be incurred by
18 the contractor in the period to be covered by the rate;

19 (mm) Costs of outside activities, for example, costs allocated to
20 the use of a vehicle for personal purposes or related to the part of a
21 facility leased out for office space;

22 (nn) Travel expenses outside the states of Idaho, Oregon, and
23 Washington and the province of British Columbia. However, travel to or
24 from the home or central office of a chain organization operating a
25 nursing facility is allowed whether inside or outside these areas if
26 the travel is necessary, ordinary, and related to resident care;

27 (oo) Moving expenses of employees in the absence of demonstrated,
28 good-faith effort to recruit within the states of Idaho, Oregon, and
29 Washington, and the province of British Columbia;

30 (pp) Depreciation in excess of four thousand dollars per year for
31 each passenger car or other vehicle primarily used by the
32 administrator, facility staff, or central office staff;

33 (qq) Costs for temporary health care personnel from a nursing pool
34 not registered with the secretary of the department of health;

35 (rr) Payroll taxes associated with compensation in excess of
36 allowable compensation of owners, relatives, and administrative
37 personnel;

38 (ss) Costs and fees associated with filing a petition for
39 bankruptcy;

1 (tt) All advertising or promotional costs, except reasonable costs
2 of help wanted advertising;

3 (uu) Outside consultation expenses required to meet department-
4 required minimum data set completion proficiency;

5 (vv) Interest charges assessed by any department or agency of this
6 state for failure to make a timely refund of overpayments and interest
7 expenses incurred for loans obtained to make the refunds;

8 (ww) All home office or central office costs, whether on or off the
9 nursing facility premises, and whether allocated or not to specific
10 services, in excess of the median of those adjusted costs for all
11 facilities reporting such costs for the most recent report period;

12 ((and))

13 (xx) Tax expenses that a nursing facility has never incurred; and

14 (yy) All nursing facility management fees and costs.

15 **Sec. 3.** RCW 74.46.431 and 1999 c 353 s 4 are each amended to read
16 as follows:

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

24 (2) All component rate allocations shall be based upon a minimum
25 facility occupancy of ((~~eighty-five~~)) ninety percent of licensed beds,
26 regardless of how many beds are set up or in use.

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. Adjusted
35 cost report data from 1996 will be used for October 1, 1998, through
36 June 30, 2001, direct care component rate allocations; adjusted cost
37 report data from 1999 will be used for July 1, 2001, through June 30,
38 2004, direct care component rate allocations.

1 (b) Direct care component rate allocations based on 1996 cost
2 report data shall be adjusted annually for economic trends and
3 conditions by a factor or factors defined in the biennial
4 appropriations act. A different economic trends and conditions
5 adjustment factor or factors may be defined in the biennial
6 appropriations act for facilities whose direct care component rate is
7 set equal to their adjusted June 30, 1998, rate, as provided in RCW
8 74.46.506(5)(k).

9 (c) Direct care component rate allocations based on 1999 cost
10 report data shall be adjusted annually for economic trends and
11 conditions by a factor or factors defined in the biennial
12 appropriations act. A different economic trends and conditions
13 adjustment factor or factors may be defined in the biennial
14 appropriations act for facilities whose direct care component rate is
15 set equal to their adjusted June 30, 1998, rate, as provided in RCW
16 74.46.506(5)(k).

17 (5)(a) Therapy care component rate allocations shall be established
18 using adjusted cost report data covering at least six months. Adjusted
19 cost report data from 1996 will be used for October 1, 1998, through
20 June 30, 2001, therapy care component rate allocations; adjusted cost
21 report data from 1999 will be used for July 1, 2001, through June 30,
22 2004, therapy care component rate allocations.

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

26 (6)(a) Support services component rate allocations shall be
27 established using adjusted cost report data covering at least six
28 months. Adjusted cost report data from 1996 shall be used for October
29 1, 1998, through June 30, 2001, support services component rate
30 allocations; adjusted cost report data from 1999 shall be used for July
31 1, 2001, through June 30, 2004, support services component rate
32 allocations.

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

36 (7)(a) Operations component rate allocations shall be established
37 using adjusted cost report data covering at least six months. Adjusted
38 cost report data from 1996 shall be used for October 1, 1998, through
39 June 30, 2001, operations component rate allocations; adjusted cost

1 report data from 1999 shall be used for July 1, 2001, through June 30,
2 2004, operations component rate allocations.

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

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

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

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

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

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

36 **Sec. 4.** RCW 74.46.433 and 1999 c 353 s 9 are each amended to read
37 as follows:

1 (1) The department shall establish for each medicaid nursing
2 facility a variable return component rate allocation. In determining
3 the variable return allowance:

4 (a) The variable return array and percentage assigned at the
5 October 1, 1998, rate setting shall remain in effect until June 30,
6 2001, and the variable return array and percentage assigned at the July
7 1, 2001, rate setting shall remain in effect until June 30, 2004.

8 (b) To calculate the array of facilities for the July 1, 2001, rate
9 setting, the department, without using peer groups, shall first rank
10 all facilities in numerical order from highest to lowest according to
11 each facility's examined and documented, but unlidded, combined direct
12 care, therapy care, support services, and operations per resident day
13 cost from the 1999 cost report period. However, before being combined
14 with other per resident day costs and ranked, a facility's direct care
15 cost per resident day shall be adjusted to reflect its facility average
16 case mix index, to be averaged from the four calendar quarters of 1999,
17 weighted by the facility's resident days from each quarter, under RCW
18 74.46.501(7)(b)(ii). The array shall then be divided into four
19 quartiles, each containing, as nearly as possible, an equal number of
20 facilities, and four percent shall be assigned to facilities in the
21 lowest quartile, three percent to facilities in the next lowest
22 quartile, two percent to facilities in the next highest quartile, and
23 one percent to facilities in the highest quartile.

24 (c) The department shall ~~((then))~~ compute the variable return
25 allowance by multiplying ~~((the appropriate))~~ a facility's assigned
26 percentage ~~((amounts, which shall not be less than one percent and not~~
27 ~~greater than four percent,))~~ by the sum of the facility's direct care,
28 therapy care, support services, and operations ~~((rate))~~ component~~((s))~~
29 rates determined in accordance with this chapter and rules adopted by
30 the department. ~~((The percentage amounts will be based on groupings of~~
31 facilities according to the rankings prescribed in (a) of this
32 subsection, as applicable. Those groups of facilities with lower per
33 diem costs shall receive higher percentage amounts than those with
34 higher per diem costs.))

35 (2) The variable return rate allocation calculated in accordance
36 with this section shall be adjusted to the extent necessary to comply
37 with RCW 74.46.421.

1 **Sec. 5.** RCW 74.46.435 and 1999 c 353 s 10 are each amended to read
2 as follows:

3 (1) The property component rate allocation for each facility shall
4 be determined by dividing the sum of the reported allowable prior
5 period actual depreciation, subject to RCW 74.46.310 through 74.46.380,
6 adjusted for any capitalized additions or replacements approved by the
7 department, and the retained savings from such cost center, by the
8 greater of a facility's total resident days for the facility in the
9 prior period or resident days as calculated on (~~eighty-five~~) ninety
10 percent facility occupancy. If a capitalized addition or retirement of
11 an asset will result in a different licensed bed capacity during the
12 ensuing period, the prior period total resident days used in computing
13 the property component rate shall be adjusted to anticipated resident
14 day level.

15 (2) A nursing facility's property component rate allocation shall
16 be rebased annually, effective July 1st or October 1st as applicable,
17 in accordance with this section and this chapter.

18 (3) When a certificate of need for a new facility is requested, the
19 department, in reaching its decision, shall take into consideration
20 per-bed land and building construction costs for the facility which
21 shall not exceed a maximum to be established by the secretary.

22 (4) For the purpose of calculating a nursing facility's property
23 component rate, if a contractor elects to bank licensed beds or to
24 convert banked beds to active service, under chapter 70.38 RCW, the
25 department shall use the facility's anticipated resident occupancy
26 level subsequent to the decrease or increase in licensed bed capacity.
27 However, in no case shall the department use less than (~~eighty-five~~)
28 ninety percent occupancy of the facility's licensed bed capacity after
29 banking or conversion.

30 (5) The property component rate allocations calculated in
31 accordance with this section shall be adjusted to the extent necessary
32 to comply with RCW 74.46.421.

33 **Sec. 6.** RCW 74.46.437 and 1999 c 353 s 11 are each amended to read
34 as follows:

35 (1) Beginning July 1, 1999, the department shall establish for each
36 medicaid nursing facility a financing allowance component rate
37 allocation. The financing allowance component rate shall be rebased

1 annually, effective July 1st, in accordance with the provisions of this
2 section and this chapter.

3 (2) The financing allowance shall be determined by multiplying the
4 net invested funds of each facility by .10, and dividing by the greater
5 of a nursing facility's total resident days from the most recent cost
6 report period or resident days calculated on ((~~eighty-five~~)) ninety
7 percent facility occupancy. However, assets acquired on or after May
8 17, 1999, shall be grouped in a separate financing allowance
9 calculation that shall be multiplied by .085. The financing allowance
10 factor of .085 shall not be applied to the net invested funds
11 pertaining to new construction or major renovations receiving
12 certificate of need approval or an exemption from certificate of need
13 requirements under chapter 70.38 RCW, or to working drawings that have
14 been submitted to the department of health for construction review
15 approval, prior to May 17, 1999. If a capitalized addition or
16 retirement of an asset will result in a different licensed bed capacity
17 during the ensuing period, the prior period total resident days used in
18 computing the financing allowance shall be adjusted to the greater of
19 the anticipated resident day level or ((~~eighty-five~~)) ninety percent of
20 the new licensed bed capacity.

21 (3) In computing the portion of net invested funds representing the
22 net book value of tangible fixed assets, the same assets, depreciation
23 bases, lives, and methods referred to in RCW 74.46.330, 74.46.350,
24 74.46.360, 74.46.370, and 74.46.380, including owned and leased assets,
25 shall be utilized, except that the capitalized cost of land upon which
26 the facility is located and such other contiguous land which is
27 reasonable and necessary for use in the regular course of providing
28 resident care shall also be included. Subject to provisions and
29 limitations contained in this chapter, for land purchased by owners or
30 lessors before July 18, 1984, capitalized cost of land shall be the
31 buyer's capitalized cost. For all partial or whole rate periods after
32 July 17, 1984, if the land is purchased after July 17, 1984,
33 capitalized cost shall be that of the owner of record on July 17, 1984,
34 or buyer's capitalized cost, whichever is lower. In the case of leased
35 facilities where the net invested funds are unknown or the contractor
36 is unable to provide necessary information to determine net invested
37 funds, the secretary shall have the authority to determine an amount
38 for net invested funds based on an appraisal conducted according to RCW
39 74.46.360(1).

1 (4) For the purpose of calculating a nursing facility's financing
2 allowance component rate, if a contractor elects to bank licensed beds
3 or to convert banked beds to active service, under chapter 70.38 RCW,
4 the department shall use the facility's anticipated resident occupancy
5 level subsequent to the decrease or increase in licensed bed capacity.
6 However, in no case shall the department use less than (~~eighty-five~~)
7 ninety percent occupancy of the facility's licensed bed capacity after
8 banking or conversion.

9 (5) The financing allowance rate allocation calculated in
10 accordance with this section shall be adjusted to the extent necessary
11 to comply with RCW 74.46.421.

12 **Sec. 7.** RCW 74.46.501 and 1998 c 322 s 24 are each amended to read
13 as follows:

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

19 (2)(a) In calculating a facility's two average case mix indexes for
20 each quarter, the department shall include all residents or medicaid
21 residents, as applicable, who were physically in the facility during
22 the quarter in question (January 1st through March 31st, April 1st
23 through June 30th, July 1st through September 30th, or October 1st
24 through December 31st).

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

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

33 (4)(a) In determining the number of days a resident is classified
34 into a particular case mix group, the department shall determine a
35 start date for calculating case mix grouping periods as follows:

36 (i) If a resident's initial assessment for a first stay or a return
37 stay in the nursing facility is timely completed and transmitted to the
38 department by the cutoff date under state and federal requirements and

1 as described in subsection (5) of this section, the start date shall be
2 the later of either the first day of the quarter or the resident's
3 facility admission or readmission date;

4 (ii) If a resident's significant change, quarterly, or annual
5 assessment is timely completed and transmitted to the department by the
6 cutoff date under state and federal requirements and as described in
7 subsection (5) of this section, the start date shall be the date the
8 assessment is completed;

9 (iii) If a resident's significant change, quarterly, or annual
10 assessment is not timely completed and transmitted to the department by
11 the cutoff date under state and federal requirements and as described
12 in subsection (5) of this section, the start date shall be the due date
13 for the assessment.

14 (b) If state or federal rules require more frequent assessment, the
15 same principles for determining the start date of a resident's
16 classification in a particular case mix group set forth in subsection
17 (4)(a) of this section shall apply.

18 (c) In calculating the number of days a resident is classified into
19 a particular case mix group, the department shall determine an end date
20 for calculating case mix grouping periods as follows:

21 (i) If a resident is discharged before the end of the applicable
22 quarter, the end date shall be the day before discharge;

23 (ii) If a resident is not discharged before the end of the
24 applicable quarter, the end date shall be the last day of the quarter;

25 (iii) If a new assessment is due for a resident or a new assessment
26 is completed and transmitted to the department, the end date of the
27 previous assessment shall be the earlier of either the day before the
28 assessment is due or the day before the assessment is completed by the
29 nursing facility.

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

36 (6) A threshold of ninety percent, as described and calculated in
37 this subsection, shall be used to determine the case mix index each
38 quarter. The threshold shall also be used to determine which
39 facilities' costs per case mix unit are included in determining the

1 ceiling, floor, and price. If the facility does not meet the ninety
2 percent threshold, the department may use an alternate case mix index
3 to determine the facility average and medicaid average case mix indexes
4 for the quarter. The threshold is a count of unique minimum data set
5 assessments, and it shall include resident assessment instrument
6 tracking forms for residents discharged prior to completing an initial
7 assessment. The threshold is calculated by dividing ((the)) a
8 facility's count of ((~~unique minimum data set assessments~~)) residents
9 being assessed by the average census for ((each)) the facility. A
10 daily census shall be reported by each nursing facility as it transmits
11 assessment data to the department. The department shall compute a
12 quarterly average census based on the daily census. If no census has
13 been reported by a facility during a specified quarter, then the
14 department shall use the facility's licensed beds as the denominator in
15 computing the threshold.

16 (7)(a) Although the facility average and the medicaid average case
17 mix indexes shall both be calculated quarterly, the facility average
18 case mix index will be used only every three years in combination with
19 cost report data as specified by RCW 74.46.431 and 74.46.506, to
20 establish a facility's allowable cost per case mix unit. A facility's
21 medicaid average case mix index shall be used to update a nursing
22 facility's direct care component rate quarterly.

23 (b) The facility average case mix index used to establish each
24 nursing facility's direct care component rate shall be based on an
25 average of calendar quarters of the facility's average case mix
26 indexes.

27 (i) For October 1, 1998, direct care component rates, the
28 department shall use an average of facility average case mix indexes
29 from the four calendar quarters of 1997.

30 (ii) For July 1, 2001, direct care component rates, the department
31 shall use an average of facility average case mix indexes from the four
32 calendar quarters of 1999.

33 (c) The medicaid average case mix index used to update or
34 recalibrate a nursing facility's direct care component rate quarterly
35 shall be from the calendar quarter commencing six months prior to the
36 effective date of the quarterly rate. For example, October 1, 1998,
37 through December 31, 1998, direct care component rates shall utilize
38 case mix averages from the April 1, 1998, through June 30, 1998,
39 calendar quarter, and so forth.

1 **Sec. 8.** RCW 74.46.506 and 1999 c 353 s 5 and 1999 c 181 s 1 are
2 each reenacted and amended to read as follows:

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

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

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

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

30 (5) Beginning October 1, 1998, the department shall rebase each
31 nursing facility's direct care component rate allocation as described
32 in RCW 74.46.431, adjust its direct care component rate allocation for
33 economic trends and conditions as described in RCW 74.46.431, and
34 update its medicaid average case mix index, consistent with the
35 following:

36 (a) Reduce total direct care costs reported by each nursing
37 facility for the applicable cost report period specified in RCW
38 74.46.431(4)(a) to reflect any department adjustments, and to eliminate

1 reported resident therapy costs and adjustments, in order to derive the
2 facility's total allowable direct care cost;

3 (b) Divide each facility's total allowable direct care cost by its
4 adjusted resident days for the same report period, increased if
5 necessary to a minimum occupancy of (~~eighty-five~~) ninety percent;
6 that is, the greater of actual or imputed occupancy at (~~eighty-five~~)
7 ninety percent of licensed beds, to derive the facility's allowable
8 direct care cost per resident day;

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

12 (d) Divide each facility's adjusted allowable direct care cost per
13 resident day by the facility average case mix index for the applicable
14 quarters specified by RCW 74.46.501(7)(b) to derive the facility's
15 allowable direct care cost per case mix unit;

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

21 (f) Array separately the allowable direct care cost per case mix
22 unit for all metropolitan statistical area and for all nonmetropolitan
23 statistical area facilities, and determine the median allowable direct
24 care cost per case mix unit for each peer group, provided, that for the
25 purposes of establishing corridors under this subsection for July 1,
26 2001, and following rate setting, the medians determined for the
27 metropolitan and nonmetropolitan peer groups shall each be increased by
28 3.9 percent;

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

32 (i) Any facility whose allowable cost per case mix unit is less
33 than eighty-five percent of the facility's peer group median
34 established under (f) of this subsection shall be assigned a cost per
35 case mix unit equal to eighty-five percent of the facility's peer group
36 median, and shall have a direct care component rate allocation equal to
37 the facility's assigned cost per case mix unit multiplied by that
38 facility's medicaid average case mix index from the applicable quarter
39 specified in RCW 74.46.501(7)(c);

1 (ii) Any facility whose allowable cost per case mix unit is greater
2 than one hundred fifteen percent of the peer group median established
3 under (f) of this subsection shall be assigned a cost per case mix unit
4 equal to one hundred fifteen percent of the peer group median, and
5 shall have a direct care component rate allocation equal to the
6 facility's assigned cost per case mix unit multiplied by that
7 facility's medicaid average case mix index from the applicable quarter
8 specified in RCW 74.46.501(7)(c);

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

15 (h) Except as provided in (k) of this subsection, from July 1,
16 2000, through June 30, 2002, determine each facility's quarterly direct
17 care component rate as follows:

18 (i) Any facility whose allowable cost per case mix unit is less
19 than ninety percent of the facility's peer group median established
20 under (f) of this subsection shall be assigned a cost per case mix unit
21 equal to ninety percent of the facility's peer group median, and shall
22 have a direct care component rate allocation equal to the facility's
23 assigned cost per case mix unit multiplied by that facility's medicaid
24 average case mix index from the applicable quarter specified in RCW
25 74.46.501(7)(c);

26 (ii) Any facility whose allowable cost per case mix unit is greater
27 than one hundred ten percent of the peer group median established under
28 (f) of this subsection shall be assigned a cost per case mix unit equal
29 to one hundred ten percent of the peer group median, and shall have a
30 direct care component rate allocation equal to the facility's assigned
31 cost per case mix unit multiplied by that facility's medicaid average
32 case mix index from the applicable quarter specified in RCW
33 74.46.501(7)(c);

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

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

3 (i) Any facility whose allowable cost per case mix unit is less
4 than ninety-five percent of the facility's peer group median
5 established under (f) of this subsection shall be assigned a cost per
6 case mix unit equal to ninety-five percent of the facility's peer group
7 median, and shall have a direct care component rate allocation equal to
8 the facility's assigned cost per case mix unit multiplied by that
9 facility's medicaid average case mix index from the applicable quarter
10 specified in RCW 74.46.501(7)(c);

11 (ii) Any facility whose allowable cost per case mix unit is greater
12 than one hundred five percent of the peer group median established
13 under (f) of this subsection shall be assigned a cost per case mix unit
14 equal to one hundred five percent of the peer group median, and shall
15 have a direct care component rate allocation equal to the facility's
16 assigned cost per case mix unit multiplied by that facility's medicaid
17 average case mix index from the applicable quarter specified in RCW
18 74.46.501(7)(c);

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

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

30 (k)(i) Between October 1, 1998, and June 30, 2000, the department
31 shall compare each facility's direct care component rate allocation
32 calculated under (g) of this subsection with the facility's nursing
33 services component rate in effect on September 30, 1998, less therapy
34 costs, plus any exceptional care offsets as reported on the cost
35 report, adjusted for economic trends and conditions as provided in RCW
36 74.46.431. A facility shall receive the higher of the two rates;

37 (ii) Between July 1, 2000, and June 30, 2002, the department shall
38 compare each facility's direct care component rate allocation
39 calculated under (h) of this subsection with the facility's direct care

1 component rate in effect on June 30, 2000. A facility shall receive
2 the higher of the two rates.

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

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

13 **Sec. 9.** RCW 74.46.511 and 1999 c 353 s 6 and 1999 c 181 s 3 are
14 each reenacted and amended to read as follows:

15 (1) The therapy care component rate allocation corresponds to the
16 provision of medicaid one-on-one therapy provided by a qualified
17 therapist as defined in this chapter, including therapy supplies and
18 therapy consultation, for one day for one medicaid resident of a
19 nursing facility. The therapy care component rate allocation for
20 October 1, 1998, through June 30, 2001, shall be based on adjusted
21 therapy costs and days from calendar year 1996. The therapy component
22 rate allocation for July 1, 2001, through June 30, 2004, shall be based
23 on adjusted therapy costs and days from calendar year 1999. The
24 therapy care component rate shall be adjusted for economic trends and
25 conditions as specified in RCW 74.46.431(5)(b), and shall be determined
26 in accordance with this section.

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

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

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

36 (c) Therapy consulting expenses for all residents.

37 (3) The department shall determine for all residents the total cost
38 per unit of therapy for each type of therapy by dividing the total

1 adjusted one-on-one therapy expense for each type by the total units
2 provided for that therapy type.

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

5 (a) Those facilities located within a metropolitan statistical
6 area; and

7 (b) Those not located in a metropolitan statistical area.

8 Metropolitan statistical areas and nonmetropolitan statistical
9 areas shall be as determined by the United States office of management
10 and budget or other applicable federal office. The department shall
11 array the facilities in each peer group from highest to lowest based on
12 their total cost per unit of therapy for each therapy type. The
13 department shall determine the median total cost per unit of therapy
14 for each therapy type and add ten percent of median total cost per unit
15 of therapy. The cost per unit of therapy for each therapy type at a
16 nursing facility shall be the lesser of its cost per unit of therapy
17 for each therapy type or the median total cost per unit plus ten
18 percent for each therapy type for its peer group.

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

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

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

29 (c) The medicaid allowable one-on-one therapy expense for each
30 therapy type shall be divided by total adjusted medicaid days to arrive
31 at the medicaid one-on-one therapy cost per patient day for each
32 therapy type;

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

1 department, shall be added to the total allowable one-on-one therapy
2 expense to determine the allowable therapy cost for each therapy type;

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

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

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

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

18 **Sec. 10.** RCW 74.46.515 and 1999 c 353 s 7 are each amended to read
19 as follows:

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

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

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

28 (a) Array facilities' adjusted support services costs per adjusted
29 resident day for each facility from facilities' cost reports from the
30 applicable report year, for facilities located within a metropolitan
31 statistical area, and for those not located in any metropolitan
32 statistical area and determine the median adjusted cost for each peer
33 group;

34 (b) Set each facility's support services component rate at the
35 lower of:

36 (i) The facility's per resident day adjusted support services costs
37 from the applicable cost report period, using the greater of adjusted

1 resident days from the applicable report period or imputed occupancy at
2 ninety percent of the facility's licensed beds; or

3 (ii) The adjusted median per resident day support services cost for
4 that facility's peer group, either metropolitan statistical area or
5 nonmetropolitan statistical area, plus ten percent; and

6 (c) Adjust each facility's support services component rate for
7 economic trends and conditions as provided in RCW 74.46.431(6).

8 (4) The support services component rate allocations calculated in
9 accordance with this section shall be adjusted to the extent necessary
10 to comply with RCW 74.46.421.

11 **Sec. 11.** RCW 74.46.521 and 1999 c 353 s 8 are each amended to read
12 as follows:

13 (1) The operations component rate allocation corresponds to the
14 general operation of a nursing facility for one resident for one day,
15 including but not limited to management, administration, utilities,
16 office supplies, accounting and bookkeeping, minor building
17 maintenance, minor equipment repairs and replacements, and other
18 supplies and services, exclusive of direct care, therapy care, support
19 services, property, financing allowance, and variable return.

20 (2) Beginning October 1, 1998, the department shall determine each
21 medicaid nursing facility's operations component rate allocation using
22 cost report data specified by RCW 74.46.431(7)(a).

23 (3) To determine each facility's operations component rate
24 allocation the department shall:

25 (a) Array facilities' adjusted general operations costs per
26 adjusted resident day for each facility from facilities' cost reports
27 from the applicable report year, for facilities located within a
28 metropolitan statistical area and for those not located in a
29 metropolitan statistical area and determine the median adjusted cost
30 for each peer group;

31 (b) Set each facility's operations component rate at the lower of:

32 (i) The facility's per resident day adjusted operations costs from
33 the applicable cost report period, utilizing the greater of adjusted
34 resident days from the applicable report period or imputed occupancy at
35 ninety percent of the facility's licensed beds; or

36 (ii) The adjusted median per resident day general operations cost
37 for that facility's peer group, either metropolitan statistical area or
38 nonmetropolitan statistical area; and

1 (c) Adjust each facility's operations component rate for economic
2 trends and conditions as provided in RCW 74.46.431(7)(b).

3 (4) The operations component rate allocations calculated in
4 accordance with this section shall be adjusted to the extent necessary
5 to comply with RCW 74.46.421.

6 **Sec. 12.** RCW 74.46.711 and 1995 1st sp.s. c 18 s 69 are each
7 amended to read as follows:

8 Upon the death of a resident with a personal fund deposited with
9 the facility, the facility must convey within (~~forty-five~~) thirty
10 days the resident's funds, and a final accounting of those funds, to
11 the individual or probate jurisdiction administering the resident's
12 estate; but in the case of a resident who received long-term care
13 services paid in whole or in part by the department, the funds and
14 accounting shall be sent to the state of Washington, department of
15 social and health services, office of financial recovery. The
16 department shall establish a release procedure for use for burial
17 expenses.

18 NEW SECTION. **Sec. 13.** A new section is added to chapter 74.46 RCW
19 to read as follows:

20 (1) The methodologies for funding the medicaid share of the costs
21 of nursing facility new construction, renovation, or other capital
22 improvement projects, shall continue as provided by this chapter and
23 department rule, however, effective July 1, 2001, projects eligible for
24 this funding shall not exceed a total dollar limit to be established by
25 the legislature.

26 (2) The department is authorized to adopt rules to administer the
27 capital funding limit in a way that ensures:

28 (a) All capital improvement projects receive prior approval upon
29 application for funding submitted to the department prior to a deadline
30 for each state fiscal year, to be established by the department; and

31 (b) Projects approved for funding receive complete funding of the
32 medicaid share of applicable costs, and those that are not approved
33 receive no funding prior to approval.

34 (3) Nothing in this section is intended to alter the
35 responsibilities or functions of the department of health in
36 administering the certificate of need program or the construction
37 review of health care facility projects, pursuant to chapter 70.38 RCW,

1 however, the department of health is authorized to consider medicaid
2 funding approval or lack of approval in reviewing nursing facility new
3 construction, renovation, and other capital improvement projects.

4 NEW SECTION. **Sec. 14.** The department of social and health
5 services shall study and develop recommendations exploring alternate
6 ways of paying for and providing care services to the state's needy
7 nursing facility residents receiving assistance under the Title XIX
8 medicaid program. The department of social and health services shall
9 report its findings and recommendations to the legislature on or before
10 September 1, 2002.

11 NEW SECTION. **Sec. 15.** The following acts or parts of acts are
12 each repealed:

13 (1) RCW 74.46.280 (Management fees, agreements--Limitation on scope
14 of services) and 1998 c 322 s 15, 1993 sp.s. c 13 s 4, & 1980 c 177 s
15 28; and

16 (2) RCW 74.46.908 (Repealer) and 1999 c 353 s 17.

17 NEW SECTION. **Sec. 16.** (1) Sections 1 through 14 of this act are
18 necessary for the immediate preservation of the public peace, health,
19 or safety, or support of the state government and its existing public
20 institutions, and take effect July 1, 2001.

21 (2) Section 15 of 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 June 29, 2001.

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