H-0824.1

HOUSE BILL 1729

State of Washington 59th Legislature 2005 Regular Session

By Representatives Fromhold, Bailey, Linville and Moeller

Read first time 02/03/2005. Referred to Committee on Appropriations.

AN ACT Relating to adjusting the medicaid reimbursement system; amending RCW 70.38.111, 74.46.020, 74.46.431, 74.46.435, 74.46.437, 74.46.445, 74.46.506, 74.46.511, and 74.46.521; providing an effective date; and declaring an emergency.

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

Sec. 1. RCW 70.38.111 and 1997 c 210 s 1 are each amended to read as follows:

(1) The department shall not require a certificate of need for the offering of an inpatient tertiary health service by:

(a) A health maintenance organization or a combination of health maintenance organizations if (i) the organization or combination of organizations has, in the service area of the organization or the service areas of the organizations in the combination, an enrollment of at least fifty thousand individuals, (ii) the facility in which the service will be provided is or will be geographically located so that the service will be reasonably accessible to such enrolled individuals, and (iii) at least seventy-five percent of the patients who can reasonably be expected to receive the tertiary health service will be

individuals enrolled with such organization or organizations in the combination;

(b) A health care facility if (i) the facility primarily provides or will provide inpatient health services, (ii) the facility is or will be controlled, directly or indirectly, by a health maintenance organization or a combination of health maintenance organizations which has, in the service area of the organization or service areas of the organizations in the combination, an enrollment of at least fifty thousand individuals, (iii) the facility is or will be geographically located so that the service will be reasonably accessible to such enrolled individuals, and (iv) at least seventy-five percent of the patients who can reasonably be expected to receive the tertiary health service will be individuals enrolled with such organization or organizations in the combination; or

(c) A health care facility (or portion thereof) if (i) the facility is or will be leased by a health maintenance organization or combination of health maintenance organizations which has, in the service area of the organization or the service areas of the organizations in the combination, an enrollment of at least fifty thousand individuals and, on the date the application is submitted under subsection (2) of this section, at least fifteen years remain in the term of the lease, (ii) the facility is or will be geographically located so that the service will be reasonably accessible to such enrolled individuals, and (iii) at least seventy-five percent of the patients who can reasonably be expected to receive the tertiary health service will be individuals enrolled with such organization;

if, with respect to such offering or obligation by a nursing home, the department has, upon application under subsection (2) of this section, granted an exemption from such requirement to the organization, combination of organizations, or facility.

(2) A health maintenance organization, combination of health maintenance organizations, or health care facility shall not be exempt under subsection (1) of this section from obtaining a certificate of need before offering a tertiary health service unless:

(a) It has submitted at least thirty days prior to the offering of services reviewable under RCW 70.38.105(4)(d) an application for such exemption; and

(b) The application contains such information respecting the organization, combination, or facility and the proposed offering or obligation by a nursing home as the department may require to determine if the organization or combination meets the requirements of subsection (1) of this section or the facility meets or will meet such requirements; and

(c) The department approves such application. The department shall approve or disapprove an application for exemption within thirty days of receipt of a completed application. In the case of a proposed health care facility (or portion thereof) which has not begun to provide tertiary health services on the date an application is submitted under this subsection with respect to such facility (or portion), the facility (or portion) shall meet the applicable requirements of subsection (1) of this section when the facility first provides such services. The department shall approve an application submitted under this subsection if it determines that the applicable requirements of subsection (1) of this section are met.

(3) A health care facility (or any part thereof) with respect to which an exemption was granted under subsection (1) of this section may not be sold or leased and a controlling interest in such facility or in a lease of such facility may not be acquired and a health care facility described in (1)(c) which was granted an exemption under subsection (1) of this section may not be used by any person other than the lessee described in (1)(c) unless:

(a) The department issues a certificate of need approving the sale, lease, acquisition, or use; or

(b) The department determines, upon application, that (i) the entity to which the facility is proposed to be sold or leased, which intends to acquire the controlling interest, or which intends to use the facility is a health maintenance organization or a combination of health maintenance organizations which meets the requirements of (1)(a)(i), and (ii) with respect to such facility, meets the requirements of (1)(a)(ii) or (iii) or the requirements of (1)(b)(i) and (ii).

(4) In the case of a health maintenance organization, an ambulatory care facility, or a health care facility, which ambulatory or health care facility is controlled, directly or indirectly, by a health maintenance organization or a combination of health maintenance

organizations, the department may under the program apply its certificate of need requirements only to the offering of inpatient tertiary health services and then only to the extent that such offering is not exempt under the provisions of this section.

(5)(a) The department shall not require a certificate of need for the construction, development, or other establishment of a nursing home, or the addition of beds to an existing nursing home, that is owned and operated by a continuing care retirement community that:

(i) Offers services only to contractual members;

(ii) Provides its members a contractually guaranteed range of services from independent living through skilled nursing, including some assistance with daily living activities;

(iii) Contractually assumes responsibility for the cost of services exceeding the member's financial responsibility under the contract, so that no third party, with the exception of insurance purchased by the retirement community or its members, but including the medicaid program, is liable for costs of care even if the member depletes his or her personal resources;

(iv) Has offered continuing care contracts and operated a nursing home continuously since January 1, 1988, or has obtained a certificate of need to establish a nursing home;

(v) Maintains a binding agreement with the state assuring that financial liability for services to members, including nursing home services, will not fall upon the state;

(vi) Does not operate, and has not undertaken a project that would result in a number of nursing home beds in excess of one for every four living units operated by the continuing care retirement community, exclusive of nursing home beds; and

(vii) Has obtained a professional review of pricing and long-term solvency within the prior five years which was fully disclosed to members.

(b) A continuing care retirement community shall not be exempt under this subsection from obtaining a certificate of need unless:

(i) It has submitted an application for exemption at least thirty days prior to commencing construction of, is submitting an application for the licensure of, or is commencing operation of a nursing home, whichever comes first; and

(ii) The application documents to the department that the continuing care retirement community qualifies for exemption.

(c) The sale, lease, acquisition, or use of part or all of a continuing care retirement community nursing home that qualifies for exemption under this subsection shall require prior certificate of need approval to qualify for licensure as a nursing home unless the department determines such sale, lease, acquisition, or use is by a continuing care retirement community that meets the conditions of (a) of this subsection.

(6) A rural hospital, as defined by the department, reducing the number of licensed beds to become a rural primary care hospital under the provisions of Part A Title XVIII of the Social Security Act Section 1820, 42 U.S.C., 1395c et seq. may, within three years of the reduction of beds licensed under chapter 70.41 RCW, increase the number of licensed beds to no more than the previously licensed number without being subject to the provisions of this chapter.

(7) A rural health care facility licensed under RCW 70.175.100 formerly licensed as a hospital under chapter 70.41 RCW may, within three years of the effective date of the rural health care facility license, apply to the department for a hospital license and not be subject to the requirements of RCW 70.38.105(4)(a) as the construction, development, or other establishment of a new hospital, provided there is no increase in the number of beds previously licensed under chapter 70.41 RCW and there is no redistribution in the number of beds used for acute care or long-term care, the rural health care facility has been in continuous operation, and the rural health care facility has not been purchased or leased.

(8)(a) A nursing home that voluntarily reduces the number of its licensed beds to provide assisted living, licensed boarding home care, adult day care, adult day health, respite care, hospice, outpatient therapy services, congregate meals, home health, or senior wellness clinic, or to reduce to one or two the number of beds per room or to otherwise enhance the quality of life for residents in the nursing home, may convert the original facility or portion of the facility back, and thereby increase the number of nursing home beds to no more than the previously licensed number of nursing home beds without obtaining a certificate of need under this chapter, provided the facility has been in continuous operation and has not been purchased or

leased. Any conversion to the original licensed bed capacity, or to any portion thereof, shall comply with the same life and safety code requirements as existed at the time the nursing home voluntarily reduced its licensed beds; unless waivers from such requirements were issued, in which case the converted beds shall reflect the conditions or standards that then existed pursuant to the approved waivers.

(b) To convert beds back to nursing home beds under this subsection, the nursing home must:

(i) Give notice of its intent to preserve conversion options to the department of health no later than thirty days after the effective date of the license reduction; and

(ii) Give notice to the department of health and to the department of social and health services of the intent to convert beds back. If construction is required for the conversion of beds back, the notice of intent to convert beds back must be given, at a minimum, one year prior to the effective date of license modification reflecting the restored beds; otherwise, the notice must be given a minimum of ninety days prior to the effective date of license modification reflecting the restored beds. Prior to any license modification to convert beds back to nursing home beds under this section, the licensee must demonstrate that the nursing home meets the certificate of need exemption requirements of this section.

The term "construction," as used in (b)(ii) of this subsection, is limited to those projects that are expected to equal or exceed the expenditure minimum amount, as determined under this chapter.

(c) Conversion of beds back under this subsection must be completed no later than ((~~four~~)) ten years after the effective date of the license reduction. However, for good cause shown, the ((~~four~~)) ten-year period for conversion may be extended by the department of health for one additional ((~~four~~)) ten-year period. Contractors currently banking beds under the provisions of this chapter shall be granted an additional ten-year period upon the expiration of the bed-banking period currently in effect.

(d) Nursing home beds that have been voluntarily reduced under this section shall be counted as available nursing home beds for the purpose of evaluating need under RCW 70.38.115(2) (a) and (k) so long as the facility retains the ability to convert them back to nursing home use under the terms of this section.

(e) When a building owner has secured an interest in the nursing home beds, which are intended to be voluntarily reduced by the licensee under (a) of this subsection, the applicant shall provide the department with a written statement indicating the building owner's approval of the bed reduction.

Sec. 2. RCW 74.46.020 and 2001 1st sp.s. c 8 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) "Actual patient day" means a calendar day of care provided to a nursing facility resident, regardless of payment source, which includes the day of admission and excludes the day of discharge. When used for rate setting purposes, the term "actual patient days" or "total patient days" means the total number of days of care provided to residents by the nursing facility regardless of payment sources.

(3) "Adjusted patient days" or "adjusted resident days" or "audited patient days" means those actual patient days accepted by the department for rate setting purposes after a desk review or desk audit.

(4) "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)~~)) (5) "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)~~)) (6) "Assets" means economic resources of the contractor, recognized and measured in conformity with generally accepted accounting principles.

((~~(5)~~)) (7) "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)~~)) (8) "Bad debts" means amounts considered to be uncollectible from accounts and notes receivable.

((~~(7)~~)) (9) "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)~~)) (10) "Capitalization" means the recording of an expenditure as an asset.

((~~(9)~~)) (11) "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.

((~~(10)~~)) (12) "Case mix index" means a number representing the average case mix of a nursing facility.

((~~(11)~~)) (13) "Case mix weight" means a numeric score that identifies the relative resources used by a particular group of a nursing facility's residents.

((~~(12)~~)) (14) "Certificate of capital authorization" means a certification from the department for an allocation from the biennial

capital financing authorization for all new or replacement building construction, or for major renovation projects, receiving a certificate of need or a certificate of need exemption under chapter 70.38 RCW after July 1, 2001.

((~~(13)~~)) (15) "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)~~)) (16) "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)~~)) (17) "Department" means the department of social and health services (DSHS) and its employees.

((~~(16)~~)) (18) "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)~~)) (19) "Direct care" means nursing care and related care provided to nursing facility residents. Therapy care shall not be considered part of direct care.

((~~(18)~~)) (20) "Direct care supplies" means medical, pharmaceutical, and other supplies required for the direct care of a nursing facility's residents.

((~~(19)~~)) (21) "Entity" means an individual, partnership, corporation, limited liability company, or any other association of individuals capable of entering enforceable contracts.

((~~(20)~~)) (22) "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)~~)) (23) "Essential community provider" means a facility which is the only nursing facility within a commuting distance radius of at least forty minutes duration, traveling by automobile.

((~~(22)~~)) (24) "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.

((~~(23)~~)) (25) "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.

((~~(24)~~)) (26) "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.

((~~(25)~~)) (27) "Generally accepted accounting principles" means accounting principles approved by the financial accounting standards board (FASB).

((~~(26)~~)) (28) "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.

((~~(27)~~)) (29) "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.

((~~(28)~~)) (30) "High labor-cost county" means an urban county in which the median allowable facility cost per case mix unit is more than ten percent higher than the median allowable facility cost per case mix unit among all other urban counties, excluding that county.

((~~(29)~~)) (31) "Historical cost" means the actual cost incurred in acquiring and preparing an asset for use, including feasibility studies, architect's fees, and engineering studies.

((~~(30)~~)) (32) "Home and central office costs" means costs that are incurred in the support and operation of a home and central office. Home and central office costs include centralized services that are performed in support of a nursing facility. The department may exclude from this definition costs that are nonduplicative, documented, ordinary, necessary, and related to the provision of care services to authorized patients.

((~~(31)~~)) (33) "Imprest fund" means a fund which is regularly replenished in exactly the amount expended from it.

((~~(32)~~)) (34) "Joint facility costs" means any costs which represent resources which benefit more than one facility, or one facility and any other entity.

((~~(33)~~)) (35) "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.

((~~(34)~~)) (36) "Licensed beds" or "licensed bed capacity" means a facility's occupied bed and beds available for occupancy. "Licensed beds" or "licensed bed capacity" shall never include beds banked under chapter 70.38 RCW or beds permanently removed from service under the provisions of this chapter.

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

((~~(35)~~)) (38) "Medical care recipient," "medicaid recipient," or "recipient" means an individual determined eligible by the department for the services provided under chapter 74.09 RCW.

((~~(36)~~)) (39) "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.

((~~(37)~~)) (40) "Net book value" means the historical cost of an asset less accumulated depreciation.

((~~(38)~~)) (41) "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.

((~~(39)~~)) (42) "Nonurban county" means a county which is not located in a metropolitan statistical area as determined and defined by the United States office of management and budget or other appropriate agency or office of the federal government.

((~~(40)~~)) (43) "Operating lease" means a lease under which rental or lease expenses are included in current expenses in accordance with generally accepted accounting principles.

((~~(41)~~)) (44) "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.

((~~(42)~~)) (45) "Ownership interest" means all interests beneficially owned by a person, calculated in the aggregate, regardless of the form which such beneficial ownership takes.

((~~(43)~~)) (46) "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.

((~~(44)~~)) (47) "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.

((~~(45)~~)) (48) "Provider fees" means taxes and assessments levied by any state or local government, in the form of real estate or property taxes, the quality maintenance fee levied pursuant to chapter 82.71

RCW, and the business and occupation tax levied pursuant to chapter 82.04 RCW.

(49) "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.

((~~(46)~~)) (50) "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.

((~~(47)~~)) (51) "Real property," whether leased or owned by the contractor, means the building, allowable land, land improvements, and building improvements associated with a nursing facility.

((~~(48)~~)) (52) "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.

((~~(49)~~)) (53) "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.

((~~(50)~~)) (54) "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.

((~~(51)~~)) (55) "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.

((~~(52)~~)) (56) "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.

((~~(53)~~)) (57) "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.

((~~(54)~~)) (58) "Resource utilization groups" means a case mix classification system that identifies relative resources needed to care for an individual nursing facility resident.

((~~(55)~~)) (59) "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.

((~~(56)~~)) (60) "Secretary" means the secretary of the department of social and health services.

((~~(57)~~)) (61) "Support services" means food, food preparation, dietary, housekeeping, and laundry services provided to nursing facility residents.

((~~(58)~~)) (62) "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.

((~~(59)~~)) (63) "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.

((~~(60)~~)) (64) "Total beds" or "total bed capacity" means the total number of beds certified by the facility's certificate of need. "Total beds" or "total bed capacity" means occupied beds, beds available for occupancy, and beds banked under chapter 70.38 RCW.

(65) "Urban county" means a county which is located in a metropolitan statistical area as determined and defined by the United States office of management and budget or other appropriate agency or office of the federal government.

Sec. 3. RCW 74.46.431 and 2004 c 276 s 913 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. Effective July 1, 2005, the property component rate shall be known as the property and tax component.

(2) ((~~All component rate allocations for essential community providers as defined in this chapter shall be based upon a minimum facility occupancy of eighty-five percent of licensed beds, regardless of how many beds are set up or in use. For all facilities other than essential community providers, effective July 1, 2001, component rate allocations in direct care, therapy care, support services, variable return, operations, property, and financing allowance shall continue to be based upon a minimum facility occupancy of eighty-five percent of licensed beds.~~)) For all facilities, effective July 1, 2005, component rate allocations in direct care, therapy care, support services, and operations shall be based upon actual facility occupancy. For all facilities other than essential community providers, effective July 1, 2002, the component rate allocations in ((~~operations,~~)) property((~~,~~)) and financing allowance shall be based upon a minimum facility occupancy of ninety percent of licensed beds, regardless of how many beds are set up or in use.

(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, 2005, direct care component rate allocations. Effective for the July 1, 2005, rate setting, a direct care component rate allocation shall be established using adjusted cost report data from 2003 adjusted for inflation. The 2003 cost report data shall be adjusted to reflect 1999 audited cost report ratios of allowable costs to disallowed costs. If 2003 cost report data is unavailable, actual current audited findings shall be used.

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

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

(d) Direct care component rate allocations based on 2003 cost report data shall be adjusted annually for economic trends and conditions. The annual inflation factor used to adjust the component

rate shall be based on the *Centers for Medicaid and Medicare Services Total Skilled Nursing Facility Market Basket Index* published by Data Resources, Inc.

(5)(a) Therapy care component rate allocations shall be established using adjusted cost report data covering at least six months. Adjusted cost report data from 1996 will be used for October 1, 1998, through June 30, 2001, therapy care component rate allocations; adjusted cost report data from 1999 will be used for July 1, 2001, through June 30, 2005, therapy care component rate allocations. Effective for the July 1, 2005, rate setting, therapy care component rate allocations shall be established using adjusted cost report data from 2003. The 2003 cost report data shall be adjusted to reflect 1999 audited cost report ratios of allowable costs to disallowed costs. If 2003 cost report data is unavailable, actual current audit findings shall be used.

(b) Therapy care component rate allocations ((~~shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act~~)) based on 2003 cost report data shall be adjusted annually for economic trends and conditions. The annual inflation factor used to adjust the component rate shall be based on the *Centers for Medicaid and Medicare Services Total Skilled Nursing Facility Market Basket Index* published by Data Resources, Inc.

(6)(a) Support services component rate allocations shall be established using adjusted cost report data covering at least six months. Adjusted cost report data from 1996 shall be used for October 1, 1998, through June 30, 2001, support services component rate allocations; adjusted cost report data from 1999 shall be used for July 1, 2001, through June 30, 2005, support services component rate allocations. Effective for the July 1, 2005, rate setting, support services component rate allocations shall be established using adjusted cost report data from 2003. The 2003 cost report data shall be adjusted to reflect 1999 audited cost report ratios of allowable costs to disallowed costs. If 2003 cost report data is unavailable, actual current audited findings shall be used.

(b) Support services component rate allocations ((~~shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act~~)) based on 2003 cost report data shall be adjusted annually for economic trends and conditions.

The annual inflation factor used to adjust the component rate shall be based on the *Centers for Medicaid and Medicare Services Total Skilled Nursing Facility Market Basket Index* published by Data Resources, Inc.

(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, 2005, operations component rate allocations. Effective for the July 1, 2005, rate setting, operations component rate allocations shall be established using adjusted cost report data from 2003. The 2003 cost report data shall be adjusted to reflect 1999 audited cost report ratios of allowable costs to disallowed costs. If 2003 cost report data is unavailable, actual current audited findings shall be used.

(b) Operations component rate allocations ((~~shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act~~)) based on 2003 cost report data shall be adjusted annually for economic trends and conditions. The annual inflation factor used to adjust the component rate shall be based on the *Centers for Medicaid and Medicare Services Total Skilled Nursing Facility Market Basket Index* published by Data Resources, Inc.

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

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

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

(11) The department shall establish in rule procedures, principles, and conditions for determining component rate allocations for facilities in circumstances not directly addressed by this chapter, including but not limited to: The need to prorate inflation for

partial-period cost report data, newly constructed facilities, existing facilities entering the medicaid program for the first time or after a period of absence from the program, existing facilities with expanded new bed capacity, existing medicaid facilities following a change of ownership of the nursing facility business, facilities banking beds or converting beds back into service, facilities temporarily reducing the number of set-up beds during a remodel, facilities having less than six months of either resident assessment, cost report data, or both, under the current contractor prior to rate setting, and other circumstances.

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

(13) ((~~Effective July 1, 2001, medicaid rates shall continue to be revised downward in all components, in accordance with department rules, for facilities converting banked beds to active service under chapter 70.38 RCW, by using the facility's increased licensed bed capacity to recalculate minimum occupancy for rate setting. However,~~)) For facilities ((~~other than essential community providers~~)) which bank beds under chapter 70.38 RCW, ((~~after May 25, 2001,~~)) medicaid rates shall be revised upward, in accordance with department rules, ((~~in direct care, therapy care, support services, and variable return components only, by using the facility's decreased licensed bed capacity to recalculate minimum occupancy for rate setting, but no upward revision shall be made to operations, property, or financing allowance component rates~~)) by using the facility's decreased licensed bed capacity to recalculate occupancy for all rate settings. The effective date of the recalculated prospective rate for beds banked from service shall be the first of the month:

(a) In which the beds are banked from service when the beds are banked on the first of the month;

(b) Following the month in which the banked beds returned to service when the beds are returned to service after the first of the month.

(14) In order to allow a facility the opportunity to fill beds, facilities converting banked beds to active service under chapter 70.38 RCW, the increased licensed bed capacity shall not be used to

recalculate occupancy for six months or until the next annual scheduled July 1 rate setting, whichever is longer. After the department recalculates the contractor's prospective medicaid component rate allocations using the increased number of licensed beds, the department shall use the increased number of licensed beds in all subsequent rate settings, until under this chapter the number of licensed beds changes.

((~~(14)~~)) (15) Facilities obtaining a certificate of need or a certificate of need exemption under chapter 70.38 RCW after June 30, 2001, must have a certificate of capital authorization in order for (a) the depreciation resulting from the capitalized addition to be included in calculation of the facility's property and tax component rate allocation; and (b) the net invested funds associated with the capitalized addition to be included in calculation of the facility's financing allowance rate allocation.

Sec. 4. RCW 74.46.435 and 2001 1st sp.s. c 8 s 7 are each amended to read as follows:

(1) Effective July 1, 2001, the property component rate allocation for each facility shall be determined by dividing the sum of the reported allowable prior period actual depreciation, subject to RCW 74.46.310 through 74.46.380, adjusted for any capitalized additions or replacements approved by the department, and the retained savings from such cost center, by the greater of a facility's total resident days for the facility in the prior period or resident days as calculated on eighty-five percent facility occupancy. Effective July 1, 2002, the property component rate allocation for all facilities, except essential community providers, shall be set by using the greater of a facility's total resident days from the most recent cost report period or resident days calculated at ninety percent facility occupancy. If a capitalized addition or retirement of an asset will result in a different licensed bed capacity during the ensuing period, the prior period total resident days used in computing the property component rate shall be adjusted to anticipated resident day level.

(2) Effective for the July 1, 2005, rate setting the property and tax component rate allocation for all facilities shall be set by using a facility's total resident days from the most recent cost report period. If a capitalized addition or retirement of an asset will

result in a different licensed bed capacity during the ensuing period, the prior period total resident days used in computing the property component rate shall be adjusted to anticipated resident day level.

(3) A nursing facility's property component rate allocation shall be rebased annually, effective July 1st, in accordance with this section and this chapter. Effective July 1, 2005, the property component rate shall be termed the property and tax component rate.

((~~(3)~~)) (4) When a certificate of need for a new facility is requested, the department, in reaching its decision, shall take into consideration per-bed land and building construction costs for the facility which shall not exceed a maximum to be established by the secretary.

((~~(4) Effective July 1, 2001, for the purpose of calculating a nursing facility's property component rate,~~)) (5) If a contractor ((~~has elected to bank licensed beds prior to April 1, 2001, or~~)) elects to convert banked beds to active service at any time, under chapter 70.38 RCW, the department shall use the facility's new licensed bed capacity to recalculate minimum occupancy for rate setting and revise the property component rate((~~, as needed, effective as of the date the beds are banked or converted to active service. However, in no case shall the department use less than eighty-five percent occupancy of the facility's licensed bed capacity after banking or conversion. Effective July 1, 2002, in no case, other than essential community providers, shall the department use less than ninety percent occupancy of the facility's licensed bed capacity after conversion~~)) as defined in RCW 74.46.431(14).

((~~(5)~~)) (6) The property and tax component rate allocations calculated in accordance with this section shall be adjusted to the extent necessary to comply with RCW 74.46.421.

(7) Beginning July 1, 2005, and effective every year thereafter, the department shall grant a property and business tax add-on rate to the property and tax component rate. The property and business tax add-on rate shall be revised annually.

(a) The property and business tax add-on rate shall be determined by dividing the sum of property taxes, business taxes, and other provider fees of the reported period by a facility's total resident days for the facility in the prior period. Minimum occupancy levels

shall not be used in calculating the property and business tax add-on rate.

(b) The property and business tax add-on rate shall be added to the per-resident day payment rate for the property and tax component rate.

Sec. 5. RCW 74.46.437 and 2001 1st sp.s. c 8 s 8 are each amended to read as follows:

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

(2) Effective July 1, 2001, the financing allowance shall be determined by multiplying the net invested funds of each facility by .10, and dividing by the greater of a nursing facility's total resident days from the most recent cost report period or resident days calculated on eighty-five percent facility occupancy. Effective July 1, 2002, the financing allowance component rate allocation for all facilities, other than essential community providers, shall be set by using the greater of a facility's total resident days from the most recent cost report period or resident days calculated at ninety percent facility occupancy. However, assets acquired on or after May 17, 1999, shall be grouped in a separate financing allowance calculation that shall be multiplied by .085. The financing allowance factor of .085 shall not be applied to the net invested funds pertaining to new construction or major renovations receiving certificate of need approval or an exemption from certificate of need requirements under chapter 70.38 RCW, or to working drawings that have been submitted to the department of health for construction review approval, prior to May 17, 1999. If a capitalized addition, renovation, replacement, or retirement of an asset will result in a different licensed bed capacity during the ensuing period, the prior period total resident days used in computing the financing allowance shall be adjusted to the greater of the anticipated resident day level or eighty-five percent of the new licensed bed capacity. Effective July 1, 2002, for all facilities, other than essential community providers, the total resident days used to compute the financing allowance after a capitalized addition, renovation, replacement, or retirement of an asset shall be set by

using the greater of a facility's total resident days from the most recent cost report period or resident days calculated at ninety percent facility occupancy.

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

(4) ((~~Effective July 1, 2001, for the purpose of calculating a nursing facility's financing allowance component rate,~~)) If a contractor ((~~has elected to bank licensed beds prior to May 25, 2001, or~~)) elects to convert banked beds to active service at any time, under chapter 70.38 RCW, the department shall use the facility's new licensed bed capacity to recalculate minimum occupancy for rate setting and revise the financing allowance component rate((~~, as needed, effective as of the date the beds are banked or converted to active service. However, in no case shall the department use less than eighty-five percent occupancy of the facility's licensed bed capacity after banking or conversion. Effective July 1, 2002, in no case, other than for essential community providers, shall the department use less than ninety percent occupancy of the facility's licensed bed capacity after conversion~~)) as defined in RCW 74.46.431(14). If a contractor has elected to bank licensed beds, the department shall use the facility's new licensed bed capacity to recalculate minimum occupancy for rate

setting and revise the financing allowance component rate effective as of the date the beds are banked. When beds are banked, the revised prospective medicaid payment rate will be effective the first of the month:

(a) In which the beds are banked when the beds are banked on the first of the month; or

(b) Following the month in which beds are banked when the beds are banked after the first of the month.

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

Sec. 6. RCW 74.46.445 and 1999 c 353 s 15 are each amended to read as follows:

If a contractor experiences an increase in state or county property taxes as a result of new building construction, replacement building construction, or substantial building additions ((~~that require the acquisition of land~~)), then the department shall adjust the contractor's prospective rates to cover the medicaid share of the tax increase. The rate adjustments shall only apply to construction and additions completed on or after July 1, 1997. The rate adjustments authorized by this section are effective on the first day after July 1, 1999, on which the increased tax payment is due. Rate adjustments made under this section are subject to all applicable cost limitations contained in this chapter.

Sec. 7. RCW 74.46.506 and 2001 1st sp.s. c 8 s 10 are each 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, and 2003, for rate periods as specified in RCW 74.46.431(4)(a).

(5) Beginning October 1, 1998, and annually thereafter beginning July 1, 2005, 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), or (d) 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) Effective for July 1, 2001, rate setting, divide nursing facilities into at least two and, if applicable, three peer groups: Those located in nonurban counties; those located in high labor-cost counties, if any; and those located in other urban counties;

(f) Array separately the allowable direct care cost per case mix unit for all facilities in nonurban counties; for all facilities in high labor-cost counties, if applicable; and for all facilities in other urban counties, and determine the median allowable direct care cost per case mix unit for each peer group;

(g) ((~~Except as provided in (i) 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 (i) of this subsection,~~)) From July 1, 2000, forward, and for all future rate setting, 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)(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. A facility shall receive the higher of the two rates. Between July 1, 2001, and June 30, 2002, if during any quarter a facility whose rate paid under (h) of this~~

~~subsection is greater than either the direct care rate in effect on June 30, 2000, or than that facility's allowable direct care cost per case mix unit calculated in (d) of this subsection multiplied by that facility's medicaid average case mix index from the applicable quarter specified in RCW 74.46.501(7)(c), the facility shall be paid in that and each subsequent quarter pursuant to (h) of this subsection and shall not be entitled to the greater of the two rates.~~

~~(iii) Effective July 1, 2002, all direct care component rate allocations shall be as determined under (h) of this subsection.~~))

(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.

(8) Beginning July 1, 2005, and effective every year thereafter, the department shall include liability and casualty insurance costs in the direct care component rate. "Insurance costs" shall include the costs of maintaining insurance coverage and/or membership in insurance risk pools, or purchasing equity shares in risk retention groups.

(9) Effective July 1, 2005, and effective every year thereafter, the department shall grant an insurance add-on rate to the direct care component rate. To determine the insurance add-on rate to the direct care component, the department shall:

(a) Divide each facility's total allowable insurance cost for the preceding calendar year by its total adjusted resident days for the most recent report period to derive the facility's allowable insurance cost per-resident day;

(b) Array facilities' adjusted insurance cost per adjusted resident day for each facility and determine the median allowable insurance cost per-resident day; and

(c) Set each facility's insurance add-on rate at the lesser of:

(i) The facility's per-resident day adjusted insurance cost from the applicable cost report period; or

(ii) One hundred ten percent of the median established under (b) of this subsection.

(10) The computed insurance add-on rate shall be added to the per-resident day payment rate for the direct care component rate.

Sec. 8. RCW 74.46.511 and 2001 1st sp.s. c 8 s 11 are each amended to read as follows:

(1) The therapy care component rate allocation corresponds to the provision of medicaid one-on-one therapy provided by a qualified therapist as defined in this chapter, including therapy supplies and therapy consultation, for one day for one medicaid resident of a nursing facility. The therapy care component rate allocation for October 1, 1998, through June 30, 2001, shall be based on adjusted therapy costs and days from calendar year 1996. The therapy component rate allocation for July 1, 2001, through June 30, 2004, shall be based on adjusted therapy costs and days from calendar year 1999. The therapy component rate allocation for July 1, 2005, shall be based on adjusted therapy costs and days from calendar year 2003. The therapy care component rate shall be adjusted for economic trends and conditions as specified in RCW 74.46.431(5)(b), and shall be determined in accordance with this section.

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

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

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

(c) Therapy consulting expenses for all residents.

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

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

(a) Those facilities located within urban counties; and

(b) Those located within nonurban counties.

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

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

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

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

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

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

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

(f) The total allowable therapy expense will be divided by the ((~~greater of~~)) adjusted total patient days from the cost report on which the therapy expenses were reported((~~, or patient days at eighty-~~

~~five percent occupancy of licensed beds~~)). The outcome shall be the nursing facility's therapy care component rate allocation.

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

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

Sec. 9. RCW 74.46.521 and 2001 1st sp.s. c 8 s 13 are each amended to read as follows:

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

(2) Beginning October 1, 1998, and annually thereafter, the department shall determine each medicaid nursing facility's operations component rate allocation using cost report data specified by RCW 74.46.431(7)(a). ((~~Effective July 1, 2002, operations component rates for all facilities except essential community providers shall be based upon a minimum occupancy of ninety percent of licensed beds, and no operations component rate shall be revised in response to beds banked on or after May 25, 2001, under chapter 70.38 RCW.~~))

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

(a) Array facilities' adjusted general operations costs per adjusted resident day for each facility from facilities' cost reports from the applicable report year, for facilities located within urban counties and for those located within nonurban counties and determine the median adjusted cost for each peer group;

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

(i) The facility's per resident day adjusted operations costs from

the applicable cost report period adjusted if necessary to a minimum occupancy of eighty-five percent of licensed beds before July 1, 2002, and ninety percent effective July 1, 2002; or

(ii) The adjusted median per resident day general operations cost for that facility's peer group, urban counties or nonurban counties plus ten percent; and

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

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

NEW SECTION. **Sec. 10.** This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect July 1, 2005.

--- END ---