
ENGROSSED HOUSE BILL 2716

State of Washington

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By Representatives Fromhold, Kessler, Skinner, Haigh, Strow, Moeller, Armstrong, Conway, Curtis, Murray, Buri, Green, Ericksen, Serben, McDermott, Morrell, McIntire, Appleton, Kenney, P. Sullivan, Ormsby and Linville

Read first time 01/12/2006. Referred to Committee on Appropriations.

1 AN ACT Relating to nursing facility medicaid payment systems;
2 amending RCW 74.46.020, 74.46.431, 74.46.433, 74.46.496, 74.46.501,
3 74.46.506, and 74.46.521; and providing an effective date.

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

5 **Sec. 1.** RCW 74.46.020 and 2001 1st sp.s. c 8 s 1 are each amended
6 to read as follows:

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

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

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

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

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

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

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

22 (7) "Beneficial owner" means:

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

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

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

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

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

1 (i) Through the exercise of any option, warrant, or right;
2 (ii) Through the conversion of an ownership interest;
3 (iii) Pursuant to the power to revoke a trust, discretionary
4 account, or similar arrangement; or
5 (iv) Pursuant to the automatic termination of a trust,
6 discretionary account, or similar arrangement;
7 except that, any person who acquires an ownership interest or power
8 specified in (c)(i), (ii), or (iii) of this subsection with the purpose
9 or effect of changing or influencing the control of the contractor, or
10 in connection with or as a participant in any transaction having such
11 purpose or effect, immediately upon such acquisition shall be deemed to
12 be the beneficial owner of the ownership interest which may be acquired
13 through the exercise or conversion of such ownership interest or power;
14 (d) Any person who in the ordinary course of business is a pledgee
15 of ownership interest under a written pledge agreement shall not be
16 deemed to be the beneficial owner of such pledged ownership interest
17 until the pledgee has taken all formal steps necessary which are
18 required to declare a default and determines that the power to vote or
19 to direct the vote or to dispose or to direct the disposition of such
20 pledged ownership interest will be exercised; except that:
21 (i) The pledgee agreement is bona fide and was not entered into
22 with the purpose nor with the effect of changing or influencing the
23 control of the contractor, nor in connection with any transaction
24 having such purpose or effect, including persons meeting the conditions
25 set forth in (b) of this subsection; and
26 (ii) The pledgee agreement, prior to default, does not grant to the
27 pledgee:
28 (A) The power to vote or to direct the vote of the pledged
29 ownership interest; or
30 (B) The power to dispose or direct the disposition of the pledged
31 ownership interest, other than the grant of such power(s) pursuant to
32 a pledge agreement under which credit is extended and in which the
33 pledgee is a broker or dealer.
34 (8) "Capitalization" means the recording of an expenditure as an
35 asset.
36 (9) "Case mix" means a measure of the intensity of care and
37 services needed by the residents of a nursing facility or a group of
38 residents in the facility.

- 1 (10) "Case mix index" means a number representing the average case
2 mix of a nursing facility.
- 3 (11) "Case mix weight" means a numeric score that identifies the
4 relative resources used by a particular group of a nursing facility's
5 residents.
- 6 (12) "Certificate of capital authorization" means a certification
7 from the department for an allocation from the biennial capital
8 financing authorization for all new or replacement building
9 construction, or for major renovation projects, receiving a certificate
10 of need or a certificate of need exemption under chapter 70.38 RCW
11 after July 1, 2001.
- 12 (13) "Contractor" means a person or entity licensed under chapter
13 18.51 RCW to operate a medicare and medicaid certified nursing
14 facility, responsible for operational decisions, and contracting with
15 the department to provide services to medicaid recipients residing in
16 the facility.
- 17 (14) "Default case" means no initial assessment has been completed
18 for a resident and transmitted to the department by the cut-off date,
19 or an assessment is otherwise past due for the resident, under state
20 and federal requirements.
- 21 (15) "Department" means the department of social and health
22 services (DSHS) and its employees.
- 23 (16) "Depreciation" means the systematic distribution of the cost
24 or other basis of tangible assets, less salvage, over the estimated
25 useful life of the assets.
- 26 (17) "Direct care" means nursing care and related care provided to
27 nursing facility residents. Therapy care shall not be considered part
28 of direct care.
- 29 (18) "Direct care supplies" means medical, pharmaceutical, and
30 other supplies required for the direct care of a nursing facility's
31 residents.
- 32 (19) "Entity" means an individual, partnership, corporation,
33 limited liability company, or any other association of individuals
34 capable of entering enforceable contracts.
- 35 (20) "Equity" means the net book value of all tangible and
36 intangible assets less the recorded value of all liabilities, as
37 recognized and measured in conformity with generally accepted
38 accounting principles.

1 (21) "Essential community provider" means a facility which is the
2 only nursing facility within a commuting distance radius of at least
3 forty minutes duration, traveling by automobile.

4 (22) "Facility" or "nursing facility" means a nursing home licensed
5 in accordance with chapter 18.51 RCW, excepting nursing homes certified
6 as institutions for mental diseases, or that portion of a multiservice
7 facility licensed as a nursing home, or that portion of a hospital
8 licensed in accordance with chapter 70.41 RCW which operates as a
9 nursing home.

10 (23) "Fair market value" means the replacement cost of an asset
11 less observed physical depreciation on the date for which the market
12 value is being determined.

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

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

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

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

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

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

33 (30) "Home and central office costs" means costs that are incurred
34 in the support and operation of a home and central office. Home and
35 central office costs include centralized services that are performed in
36 support of a nursing facility. The department may exclude from this
37 definition costs that are nonduplicative, documented, ordinary,

1 necessary, and related to the provision of care services to authorized
2 patients.

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

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

8 (33) "Lease agreement" means a contract between two parties for the
9 possession and use of real or personal property or assets for a
10 specified period of time in exchange for specified periodic payments.
11 Elimination (due to any cause other than death or divorce) or addition
12 of any party to the contract, expiration, or modification of any lease
13 term in effect on January 1, 1980, or termination of the lease by
14 either party by any means shall constitute a termination of the lease
15 agreement. An extension or renewal of a lease agreement, whether or
16 not pursuant to a renewal provision in the lease agreement, shall be
17 considered a new lease agreement. A strictly formal change in the
18 lease agreement which modifies the method, frequency, or manner in
19 which the lease payments are made, but does not increase the total
20 lease payment obligation of the lessee, shall not be considered
21 modification of a lease term.

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

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

28 (36) "Minimum data set" means the overall data component of the
29 resident assessment instrument, indicating the strengths, needs, and
30 preferences of an individual nursing facility resident.

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

33 (38) "Net invested funds" means the net book value of tangible
34 fixed assets employed by a contractor to provide services under the
35 medical care program, including land, buildings, and equipment as
36 recognized and measured in conformity with generally accepted
37 accounting principles.

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

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

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

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

14 (43) "Patient day" or "resident day" means a calendar day of care
15 provided to a nursing facility resident, regardless of payment source,
16 which will include the day of admission and exclude the day of
17 discharge; except that, when admission and discharge occur on the same
18 day, one day of care shall be deemed to exist. A "medicaid day" or
19 "recipient day" means a calendar day of care provided to a medicaid
20 recipient determined eligible by the department for services provided
21 under chapter 74.09 RCW, subject to the same conditions regarding
22 admission and discharge applicable to a patient day or resident day of
23 care.

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

34 (45) "Qualified therapist" means:

- 35 (a) A mental health professional as defined by chapter 71.05 RCW;
36 (b) A mental retardation professional who is a therapist approved
37 by the department who has had specialized training or one year's

1 experience in treating or working with the mentally retarded or
2 developmentally disabled;

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

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

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

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

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

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

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

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

28 (50) "Related organization" means an entity which is under common
29 ownership and/or control with, or has control of, or is controlled by,
30 the contractor.

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

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

1 (51) "Related care" means only those services that are directly
2 related to providing direct care to nursing facility residents. These
3 services include, but are not limited to, nursing direction and
4 supervision, medical direction, medical records, pharmacy services,
5 activities, and social services.

6 (52) "Resident assessment instrument," including federally approved
7 modifications for use in this state, means a federally mandated,
8 comprehensive nursing facility resident care planning and assessment
9 tool, consisting of the minimum data set and resident assessment
10 protocols.

11 (53) "Resident assessment protocols" means those components of the
12 resident assessment instrument that use the minimum data set to trigger
13 or flag a resident's potential problems and risk areas.

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

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

20 (56) "Secretary" means the secretary of the department of social
21 and health services.

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

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

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

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

36 (61) "Vital local provider" means a facility reporting a home
37 office that meets the following qualifications:

38 (a) The home office address is located in Washington state; and

1 (b) The sum of medicaid days for all Washington facilities
2 reporting the home office as their home office was greater than two
3 hundred fifteen thousand in 2003.

4 **Sec. 2.** RCW 74.46.431 and 2005 c 518 s 944 are each amended to
5 read as follows:

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

13 (2) (~~All~~) Component rate allocations in therapy care, support
14 services, variable return, operations, property, and financing
15 allowance for essential community providers as defined in this chapter
16 shall be based upon a minimum facility occupancy of eighty-five percent
17 of licensed beds, regardless of how many beds are set up or in use.
18 For all facilities other than essential community providers, effective
19 July 1, 2001, component rate allocations in direct care, therapy care,
20 support services, variable return, operations, property, and financing
21 allowance shall continue to be based upon a minimum facility occupancy
22 of eighty-five percent of licensed beds. For all facilities other than
23 essential community providers, effective July 1, 2002, the component
24 rate allocations in operations, property, and financing allowance shall
25 be based upon a minimum facility occupancy of ninety percent of
26 licensed beds, regardless of how many beds are set up or in use. For
27 all facilities, effective July 1, 2006, the component rate allocation
28 in direct care shall be based upon actual facility occupancy.

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

35 (4)(a) Direct care component rate allocations shall be established
36 using adjusted cost report data covering at least six months. Adjusted
37 cost report data from 1996 will be used for October 1, 1998, through

1 June 30, 2001, direct care component rate allocations; adjusted cost
2 report data from 1999 will be used for July 1, 2001, through June 30,
3 ((2005)) 2006, direct care component rate allocations. Adjusted cost
4 report data from ((1999)) 2003 will ((continue to)) be used for July 1,
5 ((2005)) 2006, and later direct care component rate allocations.

6 (b) Direct care component rate allocations based on 1996 cost
7 report data shall be adjusted annually for economic trends and
8 conditions by a factor or factors defined in the biennial
9 appropriations act. A different economic trends and conditions
10 adjustment factor or factors may be defined in the biennial
11 appropriations act for facilities whose direct care component rate is
12 set equal to their adjusted June 30, 1998, rate, as provided in RCW
13 74.46.506(5)(i).

14 (c) Direct care component rate allocations based on 1999 cost
15 report data shall be adjusted annually for economic trends and
16 conditions by a factor or factors defined in the biennial
17 appropriations act. A different economic trends and conditions
18 adjustment factor or factors may be defined in the biennial
19 appropriations act for facilities whose direct care component rate is
20 set equal to their adjusted June 30, 1998, rate, as provided in RCW
21 74.46.506(5)(i).

22 (d) Direct care component rate allocations based on 2003 cost
23 report data shall be adjusted annually for economic trends and
24 conditions by a factor or factors defined in the biennial
25 appropriations act. A different economic trends and conditions
26 adjustment factor or factors may be defined in the biennial
27 appropriations act for facilities whose direct care component rate is
28 set equal to their adjusted June 30, 2006, rate, as provided in RCW
29 74.46.506(5)(i).

30 (5)(a) Therapy care component rate allocations shall be established
31 using adjusted cost report data covering at least six months. Adjusted
32 cost report data from 1996 will be used for October 1, 1998, through
33 June 30, 2001, therapy care component rate allocations; adjusted cost
34 report data from 1999 will be used for July 1, 2001, through June 30,
35 2005, therapy care component rate allocations. Adjusted cost report
36 data from 1999 will continue to be used for July 1, 2005, and later
37 therapy care component rate allocations.

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

4 (6)(a) Support services component rate allocations shall be
5 established using adjusted cost report data covering at least six
6 months. Adjusted cost report data from 1996 shall be used for October
7 1, 1998, through June 30, 2001, support services component rate
8 allocations; adjusted cost report data from 1999 shall be used for July
9 1, 2001, through June 30, 2005, support services component rate
10 allocations. Adjusted cost report data from 1999 will continue to be
11 used for July 1, 2005, and later support services component rate
12 allocations.

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

16 (7)(a) Operations component rate allocations shall be established
17 using adjusted cost report data covering at least six months. Adjusted
18 cost report data from 1996 shall be used for October 1, 1998, through
19 June 30, 2001, operations component rate allocations; adjusted cost
20 report data from 1999 shall be used for July 1, 2001, through June 30,
21 ((2005)) 2006, operations component rate allocations. Adjusted cost
22 report data from ((1999)) 2003 will ((continue to)) be used for July 1,
23 ((2005)) 2006, and later operations component rate allocations.

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

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

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

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

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

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

25 (13) Effective July 1, 2001, medicaid rates shall continue to be
26 revised downward in all components, in accordance with department
27 rules, for facilities converting banked beds to active service under
28 chapter 70.38 RCW, by using the facility's increased licensed bed
29 capacity to recalculate minimum occupancy for rate setting. However,
30 for facilities other than essential community providers which bank beds
31 under chapter 70.38 RCW, after May 25, 2001, medicaid rates shall be
32 revised upward, in accordance with department rules, in direct care,
33 therapy care, support services, and variable return components only, by
34 using the facility's decreased licensed bed capacity to recalculate
35 minimum occupancy for rate setting, but no upward revision shall be
36 made to operations, property, or financing allowance component rates.
37 The direct care component rate allocation shall be adjusted, without

1 using the minimum occupancy assumption, for facilities that convert
2 banked beds to active service, under chapter 70.38 RCW, beginning on
3 July 1, 2006.

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

12 **Sec. 3.** RCW 74.46.433 and 2001 1st sp.s. c 8 s 6 are each amended
13 to read as follows:

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

17 (a) Except as provided in (e) of this subsection, the variable
18 return array and percentage shall be assigned whenever rebasing of
19 noncapital rate allocations is scheduled under RCW ((~~46.46.431~~
20 ~~[74.46.431])~~) 74.46.431 (4), (5), (6), and (7).

21 (b) To calculate the array of facilities for the July 1, 2001, rate
22 setting, the department, without using peer groups, shall first rank
23 all facilities in numerical order from highest to lowest according to
24 each facility's examined and documented, but unlidged, combined direct
25 care, therapy care, support services, and operations per resident day
26 cost from the 1999 cost report period. However, before being combined
27 with other per resident day costs and ranked, a facility's direct care
28 cost per resident day shall be adjusted to reflect its facility average
29 case mix index, to be averaged from the four calendar quarters of 1999,
30 weighted by the facility's resident days from each quarter, under RCW
31 74.46.501(7)(b)(ii). The array shall then be divided into four
32 quartiles, each containing, as nearly as possible, an equal number of
33 facilities, and four percent shall be assigned to facilities in the
34 lowest quartile, three percent to facilities in the next lowest
35 quartile, two percent to facilities in the next highest quartile, and
36 one percent to facilities in the highest quartile.

1 (c) The department shall, subject to (d) of this subsection,
2 compute the variable return allowance by multiplying a facility's
3 assigned percentage by the sum of the facility's direct care, therapy
4 care, support services, and operations component rates determined in
5 accordance with this chapter and rules adopted by the department.

6 (d) Effective July 1, 2001, if a facility's examined and documented
7 direct care cost per resident day for the preceding report year is
8 lower than its average direct care component rate weighted by medicaid
9 resident days for the same year, the facility's direct care cost shall
10 be substituted for its July 1, 2001, direct care component rate, and
11 its variable return component rate shall be determined or adjusted each
12 July 1st by multiplying the facility's assigned percentage by the sum
13 of the facility's July 1, 2001, therapy care, support services, and
14 operations component rates, and its direct care cost per resident day
15 for the preceding year.

16 (e) Effective July 1, 2006, the variable return component rate
17 allocation for each facility shall be the facility's June 30, 2006,
18 variable return component rate allocation.

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

22 **Sec. 4.** RCW 74.46.496 and 1998 c 322 s 23 are each amended to read
23 as follows:

24 (1) Each case mix classification group shall be assigned a case mix
25 weight. The case mix weight for each resident of a nursing facility
26 for each calendar quarter shall be based on data from resident
27 assessment instruments completed for the resident and weighted by the
28 number of days the resident was in each case mix classification group.
29 Days shall be counted as provided in this section.

30 (2) The case mix weights shall be based on the average minutes per
31 registered nurse, licensed practical nurse, and certified nurse aide,
32 for each case mix group, and using the health care financing
33 administration of the United States department of health and human
34 services 1995 nursing facility staff time measurement study stemming
35 from its multistate nursing home case mix and quality demonstration
36 project. Those minutes shall be weighted by statewide ratios of

1 registered nurse to certified nurse aide, and licensed practical nurse
2 to certified nurse aide, wages, including salaries and benefits, which
3 shall be based on 1995 cost report data for this state.

4 (3) The case mix weights shall be determined as follows:

5 (a) Set the certified nurse aide wage weight at 1.000 and calculate
6 wage weights for registered nurse and licensed practical nurse average
7 wages by dividing the certified nurse aide average wage into the
8 registered nurse average wage and licensed practical nurse average
9 wage;

10 (b) Calculate the total weighted minutes for each case mix group in
11 the resource utilization group III classification system by multiplying
12 the wage weight for each worker classification by the average number of
13 minutes that classification of worker spends caring for a resident in
14 that resource utilization group III classification group, and summing
15 the products;

16 (c) Assign a case mix weight of 1.000 to the resource utilization
17 group III classification group with the lowest total weighted minutes
18 and calculate case mix weights by dividing the lowest group's total
19 weighted minutes into each group's total weighted minutes and rounding
20 weight calculations to the third decimal place.

21 (4) The case mix weights in this state may be revised if the health
22 care financing administration updates its nursing facility staff time
23 measurement studies. The case mix weights shall be revised, but only
24 when direct care component rates are cost-rebased as provided in
25 subsection (5) of this section, to be effective on the July 1st
26 effective date of each cost-rebased direct care component rate.
27 However, the department may revise case mix weights more frequently if,
28 and only if, significant variances in wage ratios occur among direct
29 care staff in the different caregiver classifications identified in
30 this section.

31 (5) Case mix weights shall be revised when direct care component
32 rates are cost-rebased (~~((every three years))~~) as provided in RCW
33 74.46.431(4)((~~a~~)).

34 **Sec. 5.** RCW 74.46.501 and 2001 1st sp.s. c 8 s 9 are each amended
35 to read as follows:

36 (1) From individual case mix weights for the applicable quarter,
37 the department shall determine two average case mix indexes for each

1 medicaid nursing facility, one for all residents in the facility, known
2 as the facility average case mix index, and one for medicaid residents,
3 known as the medicaid average case mix index.

4 (2)(a) In calculating a facility's two average case mix indexes for
5 each quarter, the department shall include all residents or medicaid
6 residents, as applicable, who were physically in the facility during
7 the quarter in question based on the resident assessment instrument
8 completed by the facility and the requirements and limitations for the
9 instrument's completion and transmission (January 1st through March
10 31st, April 1st through June 30th, July 1st through September 30th, or
11 October 1st through December 31st).

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

15 (3) Both the facility average and the medicaid average case mix
16 indexes shall be determined by multiplying the case mix weight of each
17 resident, or each medicaid resident, as applicable, by the number of
18 days, as defined in this section and as applicable, the resident was at
19 each particular case mix classification or group, and then averaging.

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

23 (i) If a resident's initial assessment for a first stay or a return
24 stay in the nursing facility is timely completed and transmitted to the
25 department by the cutoff date under state and federal requirements and
26 as described in subsection (5) of this section, the start date shall be
27 the later of either the first day of the quarter or the resident's
28 facility admission or readmission date;

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

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

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

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

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

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

12 (iii) If a new assessment is due for a resident or a new assessment
13 is completed and transmitted to the department, the end date of the
14 previous assessment shall be the earlier of either the day before the
15 assessment is due or the day before the assessment is completed by the
16 nursing facility.

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

23 (6) A threshold of ninety percent, as described and calculated in
24 this subsection, shall be used to determine the case mix index each
25 quarter. The threshold shall also be used to determine which
26 facilities' costs per case mix unit are included in determining the
27 ceiling, floor, and price. For direct care component rate allocations
28 established on and after July 1, 2006, the threshold of ninety percent
29 shall be used to determine the case mix index each quarter and to
30 determine which facilities' costs per case mix unit are included in
31 determining the ceiling and price. If the facility does not meet the
32 ninety percent threshold, the department may use an alternate case mix
33 index to determine the facility average and medicaid average case mix
34 indexes for the quarter. The threshold is a count of unique minimum
35 data set assessments, and it shall include resident assessment
36 instrument tracking forms for residents discharged prior to completing
37 an initial assessment. The threshold is calculated by dividing a
38 facility's count of residents being assessed by the average census for

1 the facility. A daily census shall be reported by each nursing
2 facility as it transmits assessment data to the department. The
3 department shall compute a quarterly average census based on the daily
4 census. If no census has been reported by a facility during a
5 specified quarter, then the department shall use the facility's
6 licensed beds as the denominator in computing the threshold.

7 (7)(a) Although the facility average and the medicaid average case
8 mix indexes shall both be calculated quarterly, the facility average
9 case mix index will be used (~~only every three years~~) throughout the
10 applicable cost-rebasing period in combination with cost report data as
11 specified by RCW 74.46.431 and 74.46.506, to establish a facility's
12 allowable cost per case mix unit. A facility's medicaid average case
13 mix index shall be used to update a nursing facility's direct care
14 component rate quarterly.

15 (b) The facility average case mix index used to establish each
16 nursing facility's direct care component rate shall be based on an
17 average of calendar quarters of the facility's average case mix
18 indexes.

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

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

25 (iii) Beginning on July 1, 2006, when establishing the direct care
26 component rates, the department shall use an average of facility case
27 mix indexes from the four calendar quarters occurring during the cost
28 report period used to rebase the direct care component rate allocations
29 as specified in RCW 74.46.431.

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

1 **Sec. 6.** RCW 74.46.506 and 2001 1st sp.s. c 8 s 10 are each amended
2 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, and 2003 for rate periods as
29 specified in 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

1 74.46.431(4)(a) to reflect any department adjustments, and to eliminate
2 reported resident therapy costs and adjustments, in order to derive the
3 facility's total allowable direct care cost;

4 (b) Divide each facility's total allowable direct care cost by its
5 adjusted resident days for the same report period, increased if
6 necessary to a minimum occupancy of eighty-five percent; that is, the
7 greater of actual or imputed occupancy at eighty-five percent of
8 licensed beds, to derive the facility's allowable direct care cost per
9 resident day. However, effective July 1, 2006, each facility's
10 allowable direct care costs shall be divided by its adjusted resident
11 days without application of a minimum occupancy assumption;

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

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

19 (e) Effective for July 1, 2001, rate setting, divide nursing
20 facilities into at least two and, if applicable, three peer groups:
21 Those located in nonurban counties; those located in high labor-cost
22 counties, if any; and those located in other urban counties;

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

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

31 (i) Any facility whose allowable cost per case mix unit is less
32 than eighty-five percent of the facility's peer group median
33 established under (f) of this subsection shall be assigned a cost per
34 case mix unit equal to eighty-five percent of the facility's peer group
35 median, and shall have a direct care component rate allocation equal to
36 the facility's assigned cost per case mix unit multiplied by that
37 facility's medicaid average case mix index from the applicable quarter
38 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 (i) of this subsection, from July 1,
16 2000, (~~(forward, and for all future rate setting)~~) through June 30,
17 2006, determine each facility's quarterly direct care component rate as
18 follows:

19 (i) Any facility whose allowable cost per case mix unit is less
20 than ninety percent of the facility's peer group median established
21 under (f) of this subsection shall be assigned a cost per case mix unit
22 equal to ninety percent of the facility's peer group median, and shall
23 have a direct care component rate allocation equal to the facility's
24 assigned cost per case mix unit multiplied by that facility's medicaid
25 average case mix index from the applicable quarter specified in RCW
26 74.46.501(7)(c);

27 (ii) Any facility whose allowable cost per case mix unit is greater
28 than one hundred ten percent of the peer group median established under
29 (f) of this subsection shall be assigned a cost per case mix unit equal
30 to one hundred ten percent of the peer group median, and shall have a
31 direct care component rate allocation equal to the facility's assigned
32 cost per case mix unit multiplied by that facility's medicaid average
33 case mix index from the applicable quarter specified in RCW
34 74.46.501(7)(c);

35 (iii) Any facility whose allowable cost per case mix unit is
36 between ninety and one hundred ten percent of the peer group median
37 established under (f) of this subsection shall have a direct care

1 component rate allocation equal to the facility's allowable cost per
2 case mix unit multiplied by that facility's medicaid average case mix
3 index from the applicable quarter specified in RCW 74.46.501(7)(c);

4 (i)(i) Between October 1, 1998, and June 30, 2000, the department
5 shall compare each facility's direct care component rate allocation
6 calculated under (g) of this subsection with the facility's nursing
7 services component rate in effect on September 30, 1998, less therapy
8 costs, plus any exceptional care offsets as reported on the cost
9 report, adjusted for economic trends and conditions as provided in RCW
10 74.46.431. A facility shall receive the higher of the two rates.

11 (ii) Between July 1, 2000, and June 30, 2002, the department shall
12 compare each facility's direct care component rate allocation
13 calculated under (h) of this subsection with the facility's direct care
14 component rate in effect on June 30, 2000. A facility shall receive
15 the higher of the two rates. Between July 1, 2001, and June 30, 2002,
16 if during any quarter a facility whose rate paid under (h) of this
17 subsection is greater than either the direct care rate in effect on
18 June 30, 2000, or than that facility's allowable direct care cost per
19 case mix unit calculated in (d) of this subsection multiplied by that
20 facility's medicaid average case mix index from the applicable quarter
21 specified in RCW 74.46.501(7)(c), the facility shall be paid in that
22 and each subsequent quarter pursuant to (h) of this subsection and
23 shall not be entitled to the greater of the two rates.

24 (iii) (~~Effective~~) Between July 1, 2002, and June 30, 2006, all
25 direct care component rate allocations shall be as determined under (h)
26 of this subsection.

27 (iv) Effective July 1, 2006, for all providers, except vital local
28 providers as defined in this chapter, all direct care component rate
29 allocations shall be as determined under (j) of this subsection.

30 (v) Effective July 1, 2006, for vital local providers, as defined
31 in this chapter, direct care component rate allocations shall be
32 determined as follows:

33 (A) The department shall calculate:

34 (I) The sum of each facility's July 1, 2006, direct care component
35 rate allocation calculated under (j) of this subsection and July 1,
36 2006, operations component rate calculated under RCW 74.46.521; and

37 (II) The sum of each facility's June 30, 2006, direct care and
38 operations component rates.

1 (B) If the sum calculated under (i)(v)(A)(I) of this subsection is
2 less than the sum calculated under (i)(v)(A)(II) of this subsection,
3 the facility shall have a direct care component rate allocation equal
4 to the facility's June 30, 2006, direct care component rate allocation.

5 (C) If the sum calculated under (i)(v)(A)(I) of this subsection is
6 greater than or equal to the sum calculated under (i)(v)(A)(II) of this
7 subsection, the facility's direct care component rate shall be
8 calculated under (j) of this subsection.

9 (j) Except as provided in (i) of this subsection, from July 1,
10 2006, forward, and for all future rate setting, determine each
11 facility's quarterly direct care component rate as follows:

12 (i) Any facility whose allowable cost per case mix unit is greater
13 than one hundred twelve percent of the peer group median established
14 under (f) of this subsection shall be assigned a cost per case mix unit
15 equal to one hundred twelve percent of the peer group median, and shall
16 have a direct care component rate allocation equal to the facility's
17 assigned cost per case mix unit multiplied by that facility's medicaid
18 average case mix index from the applicable quarter specified in RCW
19 74.46.501(7)(c);

20 (ii) Any facility whose allowable cost per case mix unit is less
21 than or equal to one hundred twelve percent of the peer group median
22 established under (f) of this subsection shall have a direct care
23 component rate allocation equal to the facility's allowable cost per
24 case mix unit multiplied by that facility's medicaid average case mix
25 index from the applicable quarter specified in RCW 74.46.501(7)(c).

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

29 (7) Costs related to payments resulting from increases in direct
30 care component rates, granted under authority of RCW 74.46.508(1) for
31 a facility's exceptional care residents, shall be offset against the
32 facility's examined, allowable direct care costs, for each report year
33 or partial period such increases are paid. Such reductions in
34 allowable direct care costs shall be for rate setting, settlement, and
35 other purposes deemed appropriate by the department.

36 **Sec. 7.** RCW 74.46.521 and 2001 1st sp.s. c 8 s 13 are each amended
37 to read as follows:

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

8 (2) Except as provided in subsection (4) of this section, beginning
9 October 1, 1998, the department shall determine each medicaid nursing
10 facility's operations component rate allocation using cost report data
11 specified by RCW 74.46.431(7)(a). Effective July 1, 2002, operations
12 component rates for all facilities except essential community providers
13 shall be based upon a minimum occupancy of ninety percent of licensed
14 beds, and no operations component rate shall be revised in response to
15 beds banked on or after May 25, 2001, under chapter 70.38 RCW.

16 (3) Except as provided in subsection (4) of this section, to
17 determine each facility's operations component rate the department
18 shall:

19 (a) Array facilities' adjusted general operations costs per
20 adjusted resident day, as determined by dividing each facility's total
21 allowable operations cost by its adjusted resident days for the same
22 report period, increased if necessary to a minimum occupancy of ninety
23 percent; that is, the greater of actual or imputed occupancy at ninety
24 percent of licensed beds, for each facility from facilities' cost
25 reports from the applicable report year, for facilities located within
26 urban counties and for those located within nonurban counties and
27 determine the median adjusted cost for each peer group;

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

29 (i) The facility's per resident day adjusted operations costs from
30 the applicable cost report period adjusted if necessary to a minimum
31 occupancy of eighty-five percent of licensed beds before July 1, 2002,
32 and ninety percent effective July 1, 2002; or

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

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

1 (4)(a) Effective July 1, 2006, for any facility whose direct care
2 component rate allocation is set equal to its June 30, 2006, direct
3 care component rate allocation, as provided in RCW 74.46.506(5)(i), the
4 facility's operations component rate allocation shall also be set equal
5 to the facility's June 30, 2006, operations component rate allocation.

6 (b) The operations component rate allocation for facilities whose
7 operations component rate is set equal to their June 30, 2006,
8 operations component rate, shall be adjusted for economic trends and
9 conditions as provided in RCW 74.46.431(7)(b).

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

13 NEW SECTION. Sec. 8. This act takes effect July 1, 2006.

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