SSB 6158 - S AMD
By Senators Keiser, Parlette

ADOPTED 04/20/2007

Strike everything after the enacting clause and insert the following:

"**Sec. 1.** RCW 74.46.410 and 2001 1st sp.s. c 8 s 3 are each amended to read as follows:

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

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

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

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

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

(d) Costs associated with a construction or acquisition project requiring certificate of need approval, or exemption from the requirements for certificate of need for the replacement of existing nursing home beds, pursuant to chapter 70.38 RCW if such approval or exemption was not obtained;

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

(f) Salaries or other compensation of owners, officers, directors, stockholders, partners, principals, participants, and others associated with the contractor or its home office, including all board of directors' fees for any purpose, except reasonable compensation paid for service related to patient care;

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

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

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

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

(k) Charity and courtesy allowances;

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

(m) Vending machine expenses;

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

(o) Funeral and burial expenses;

(p) Costs of gift shop operations and inventory;

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

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

(s) Penalties and fines;

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

(u) Televisions acquired prior to July 1, 2001;

(v) Federal, state, and other income taxes;

(w) Costs of special care services except where authorized by the department;

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

(y) Expenses of profit-sharing plans;

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

(aa) Personal expenses and allowances of owners or relatives;

(bb) All expenses of maintaining professional licenses or membership in professional organizations;

(cc) Costs related to agreements not to compete;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ss) Payroll taxes associated with compensation in excess of allowable compensation of owners, relatives, and administrative personnel;

(tt) Costs and fees associated with filing a petition for bankruptcy;

(uu) All advertising or promotional costs, except reasonable costs of help wanted advertising;

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

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

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

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

(zz) Effective July 1, 2007, and for all future rate settings, any costs associated with the quality maintenance fee repealed by chapter 241, Laws of 2006.

Sec. 2. RCW 74.46.431 and 2006 c 258 s 2 are each amended to read as follows:

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

(2) Component rate allocations in therapy care, support services, variable return, operations, property, and financing allowance 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 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. For all facilities, effective July 1, 2006, the component rate allocation in direct care shall be based upon actual facility occupancy.

(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, 2006, direct care component rate allocations. Adjusted cost report data from 2003 will be used for July 1, 2006, ((~~and later~~)) through June 30, 2007, direct care component rate allocations. Adjusted cost report data from 2005 will be used for July 1, 2007, through June 30, 2009, direct care component rate allocations. Effective July 1, 2009, the direct care component rate allocation shall be rebased biennially, and thereafter for each odd-numbered year beginning July 1st, using the adjusted cost report data for the calendar year two years immediately preceding the rate rebase period, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, 2011, and so forth.

(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 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, 2006, rate, as provided in RCW 74.46.506(5)(i).

(e) Direct care component rate allocations shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act.

(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. Adjusted cost report data from 1999 will continue to be used for July 1, 2005, ((~~and later~~)) through June 30, 2007, therapy care component rate allocations. Adjusted cost report data from 2005 will be used for July 1, 2007, through June 30, 2009, therapy care component rate allocations. Effective July 1, 2009, and thereafter for each odd-numbered year beginning July 1st, the therapy care component rate allocation shall be cost rebased biennially, using the adjusted cost report data for the calendar year two years immediately preceding the rate rebase period, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, 2011, and so forth.

(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.

(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. Adjusted cost report data from 1999 will continue to be used for July 1, 2005, ((~~and later~~)) through June 30, 2007, support services component rate allocations. Adjusted cost report data from 2005 will be used for July 1, 2007, through June 30, 2009, support services component rate allocations. Effective July 1, 2009, and thereafter for each odd-numbered year beginning July 1st, the support services component rate allocation shall be cost rebased biennially, using the adjusted cost report data for the calendar year two years immediately preceding the rate rebase period, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, 2011, and so forth.

(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.

(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, 2006, operations component rate allocations. Adjusted cost report data from 2003 will be used for July 1, 2006, ((~~and later~~)) through June 30, 2007, operations component rate allocations. Adjusted cost report data from 2005 will be used for July 1, 2007, through June 30, 2009, operations component rate allocations. Effective July 1, 2009, and thereafter for each odd-numbered year beginning July 1st, the operations component rate allocation shall be cost rebased biennially, using the adjusted cost report data for the calendar year two years immediately preceding the rate rebase period, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, 2011, and so forth.

(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. A different economic trends and conditions adjustment factor or factors may be defined in the biennial appropriations act for facilities whose operations component rate is set equal to their adjusted June 30, 2006, rate, as provided in RCW 74.46.521(4).

(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. The direct care component rate allocation shall be adjusted, without using the minimum occupancy assumption, for facilities that convert banked beds to active service, under chapter 70.38 RCW, beginning on July 1, 2006.

(14) 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 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. 3. RCW 74.46.506 and 2006 c 258 s 6 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, 1999, and 2003~~)) for rate periods as specified in RCW 74.46.431(4)(a).

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

(a) Reduce total direct care costs reported by each nursing facility for the applicable cost report period specified in RCW 74.46.431(4)(a) to reflect any department adjustments, and to eliminate reported resident therapy costs and adjustments, in order to derive the facility's total allowable direct care cost;

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

(c) Adjust the facility's per resident day direct care cost by the applicable factor specified in RCW 74.46.431(4) ((~~(b), (c), and (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, through June 30, 2006, 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) Between July 1, 2002, and June 30, 2006, all direct care component rate allocations shall be as determined under (h) of this subsection.

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

(v) Effective July 1, 2006, <u>through June 30, 2007,</u> for vital local providers, as defined in this chapter, direct care component rate allocations shall be determined as follows:

(A) The department shall calculate:

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

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

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

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

(j) Except as provided in (i) of this subsection, from July 1, 2006, 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 greater than one hundred twelve 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 twelve 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);

(ii) Any facility whose allowable cost per case mix unit is less than or equal to one hundred twelve 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).

(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) Costs related to 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.

Sec. 4. 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~~)) 2007, shall be based on adjusted therapy costs and days from calendar year 1999. Effective July 1, 2007, the therapy care component rate allocation shall be based on adjusted therapy costs and days as described in RCW 74.46.431(5). 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. 5. RCW 74.46.521 and 2006 c 258 s 7 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) Except as provided in subsection (4) of this section, beginning October 1, 1998, 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) Except as provided in subsection (4) of this section, to determine each facility's operations component rate the department shall:

(a) Array facilities' adjusted general operations costs per adjusted resident day, as determined by dividing each facility's total allowable operations cost by its adjusted resident days for the same report period, increased if necessary to a minimum occupancy of ninety percent; that is, the greater of actual or imputed occupancy at ninety percent of licensed beds, 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 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; and

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

(4)(a) Effective July 1, 2006, through June 30, 2007, for any facility whose direct care component rate allocation is set equal to its June 30, 2006, direct care component rate allocation, as provided in RCW 74.46.506(5)((~~(i)~~)), the facility's operations component rate allocation shall also be set equal to the facility's June 30, 2006, operations component rate allocation.

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

(5) 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. 6.** A new section is added to chapter 74.46 RCW to read as follows:

(1) For the purposes of comparison, the department shall determine the following during the rate-setting periods for fiscal years 2008 and 2009:

(a) Each facility's June 30, 2007, combined rate for the direct care, support services, therapy, and operations components, less the quality maintenance fee; and

(b) Each facility's estimated rebased rates for the July 1, 2007, and July 1, 2008, rate-setting periods, for the direct care, support services, therapy, and operations rate components, less the quality maintenance fee, adjusted for economic trends and conditions under the 2007-2009 biennial appropriations act.

(2) For the 2007-2009 fiscal biennium, the department shall include a "hold harmless" provision after rebasing to 2005 costs for the July 1, 2007, through June 30, 2008, rate-setting period and the July 1, 2008, through June 30, 2009, rate-setting period. This "hold harmless" provision shall apply to facilities that meet both of the following conditions:

(a) Facilities whose estimated rebased rates calculated under subsection (1)(b) of this section are less than their June 30, 2007, rates calculated under subsection (1)(a) of this section; and

(b) Facilities whose combined adjusted costs per adjusted resident day in the direct care, support services, therapy, and operations cost centers were greater than the combined per resident day reimbursement rates for these cost centers in either calendar years 2004 or 2005.

For those facilities that meet the conditions in this subsection, the "hold harmless" provision shall ensure that for the July 1, 2007, through June 30, 2008, rate-setting period and for the July 1, 2008, through June 30, 2009, rate-setting period, the department shall set each facility's component rates in direct care, support services, therapy, and operations to the facility's June 30, 2007, rate, less the quality maintenance fee, adjusted for economic trends and conditions specified in the 2007-2009 biennial appropriations act.

Sec. 7. RCW 74.46.020 and 2006 c 258 s 1 are each amended to read as follows:

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

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

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

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

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

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

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

(7) "Beneficial owner" means:

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

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

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

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

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

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

(ii) Through the conversion of an ownership interest;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(55) "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) "Secretary" means the secretary of the department of social and health services.

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

(58) "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) "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) "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.

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

(a) ((~~The~~)) It reports a home office with an address ((~~is~~)) located in Washington state; and

(b) The sum of medicaid days for all Washington facilities reporting ((~~the~~)) that home office as their home office was greater than two hundred fifteen thousand in 2003; and

(c) The facility was recognized as a "vital local provider" by the department as of April 1, 2007.

The definition of "vital local provider" shall expire, and have no force or effect, after June 30, 2007. After that date, no facility's payments under this chapter shall in any way be affected by its prior determination or recognition as a vital local provider.

NEW SECTION. **Sec. 8.** 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, 2007."

SSB 6158 - S AMD
By Senators Keiser, Parlette

ADOPTED 04/20/2007

On page 1, line 2 of the title, after "rates;" strike the remainder of the title and insert "amending RCW 74.46.410, 74.46.431, 74.46.506, 74.46.511, 74.46.521, and 74.46.020; adding a new section to chapter 74.46 RCW; providing an effective date; and declaring an emergency."

EFFECT: (1) Removes the specific hold harmless provision only applying to "vital local providers," but keeps the general hold harmless provision applying to providers that meet certain criteria (which could also include vital local providers).

(2) Requires any adjustment for economic trends and conditions (vendor rate increase) in the budget to also apply to these hold harmless rates.

(3) Makes current "vital local provider" language in statute expire at the end of this biennium.

(4) Makes technical corrections to the underlying draft.

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