H-1413.1

HOUSE BILL 1829

State of Washington 60th Legislature 2007 Regular Session

By Representatives Morrell, Ericksen, Appleton, Priest, Moeller, Strow, Campbell, Conway, Wallace, Fromhold, Miloscia, Armstrong, P. Sullivan, Haler, Pettigrew, Crouse, Darneille, McDonald, Green, Hinkle, Seaquist, Simpson, VanDeWege, Lovick, O'Brien, Kenney, Rolfes and Ormsby

Read first time 01/30/2007. Referred to Committee on Appropriations.

1 AN ACT Relating to the nursing facility medicaid payment system;
2 amending RCW 74.46.020, 74.46.165, 74.46.431, 74.46.433, 74.46.435,
3 74.46.437, 74.46.439, 74.46.496, 74.46.501, 74.46.506, 74.46.508,
4 74.46.511, 74.46.515, and 74.46.521; adding new sections to chapter
5 74.46 RCW; providing an effective date; providing expiration dates; and
6 declaring an emergency.

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

8 **Sec. 1.** RCW 74.46.020 and 2006 c 258 s 1 are each amended to read
9 as follows:
10 Unless the context clearly requires otherwise, the definitions in
11 this section apply throughout this chapter.
12 (1) "Accrual method of accounting" means a method of accounting in
13 which revenues are reported in the period when they are earned,
14 regardless of when they are collected, and expenses are reported in the
15 period in which they are incurred, regardless of when they are paid.
16 (2) "Appraisal" means the process of estimating the fair market
17 value or reconstructing the historical cost of an asset acquired in a
18 past period as performed by a professionally designated real estate
19 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;

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

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

(((9))) (10) "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))) (11) "Case mix index" means a number representing the average case mix of a nursing facility.

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

(((12))) (13) "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))) (14) "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))) (15) "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))) (16) "Department" means the department of social and health services (DSHS) and its employees.

(((16))) (17) "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 one" means nursing care, including nurse aide care, provided to nursing facility residents.

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

1 ((~~(19)~~)) (20) "Direct care two" means food, food preparation,
2 dietary, housekeeping, laundry services, therapy, direct care supplies,
3 and nursing-related services not included in direct care one. Nursing-
4 related services include, but are not limited to, nursing direction and
5 supervision, medical direction, medical records, pharmacy services,
6 activities, and social services.

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

10 ((~~(20)~~)) (22) "Equity" means the net book value of all tangible and
11 intangible assets less the recorded value of all liabilities, as
12 recognized and measured in conformity with generally accepted
13 accounting principles.

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

17 ~~(22)~~)) (23) "Facility" or "nursing facility" means a nursing home
18 licensed in accordance with chapter 18.51 RCW, excepting nursing homes
19 certified as institutions for mental diseases, or that portion of a
20 multiservice facility licensed as a nursing home, or that portion of a
21 hospital licensed in accordance with chapter 70.41 RCW which operates
22 as a nursing home.

23 ((~~(23)~~)) (24) "Fair market value" means the replacement cost of an
24 asset less observed physical depreciation on the date for which the
25 market value is being determined.

26 ((~~(24)~~)) (25) "Financial statements" means statements prepared and
27 presented in conformity with generally accepted accounting principles
28 including, but not limited to, balance sheet, statement of operations,
29 statement of changes in financial position, and related notes.

30 ((~~(25)~~)) (26) "Generally accepted accounting principles" means
31 accounting principles approved by the financial accounting standards
32 board (FASB).

33 ((~~(26)~~)) (27) "Goodwill" means the excess of the price paid for a
34 nursing facility business over the fair market value of all net
35 identifiable tangible and intangible assets acquired, as measured in
36 accordance with generally accepted accounting principles.

37 ((~~(27)~~)) (28) "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)~~)) (29) "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)~~)) (30) "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)~~)) (31) "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)~~)) (32) "Imprest fund" means a fund which is regularly replenished in exactly the amount expended from it.

((~~(32)~~)) (33) "Joint facility costs" means any costs which represent resources which benefit more than one facility, or one facility and any other entity.

((~~(33)~~)) (34) "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)~~)) (35) "Medicaid census" means the facility's total medicaid

1 days in a period divided by the facility's total resident days for the
2 same period, including medicaid managed care.

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

6 (((35))) (37) "Medical care recipient," "medicaid recipient," or
7 "recipient" means an individual determined eligible by the department
8 for the services provided under chapter 74.09 RCW.

9 (((36))) (38) "Minimum data set" means the overall data component
10 of the resident assessment instrument, indicating the strengths, needs,
11 and preferences of an individual nursing facility resident.

12 (((37))) (39) "Net book value" means the historical cost of an
13 asset less accumulated depreciation.

14 (((38))) (40) "Net invested funds" means the net book value of
15 tangible fixed assets employed by a contractor to provide services
16 under the medical care program, including land, buildings, and
17 equipment as recognized and measured in conformity with generally
18 accepted accounting principles.

19 (((39))) (41) "Nonurban county" means a county which is not located
20 in a metropolitan statistical area as determined and defined by the
21 United States office of management and budget or other appropriate
22 agency or office of the federal government.

23 (((40))) (42) "Operating lease" means a lease under which rental or
24 lease expenses are included in current expenses in accordance with
25 generally accepted accounting principles.

26 (((41))) (43) "Owner" means a sole proprietor, general or limited
27 partners, members of a limited liability company, and beneficial
28 interest holders of five percent or more of a corporation's outstanding
29 stock.

30 (((42))) (44) "Ownership interest" means all interests beneficially
31 owned by a person, calculated in the aggregate, regardless of the form
32 which such beneficial ownership takes.

33 (((43))) (45) "Patient day" or "resident day" means a calendar day
34 of care provided to a nursing facility resident, regardless of payment
35 source, which will include the day of admission and exclude the day of
36 discharge; except that, when admission and discharge occur on the same
37 day, one day of care shall be deemed to exist. A "medicaid day" or
38 "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)~~)) (46) "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)~~)) (47) "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)~~)) (48) "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)~~)) (49) "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)~~)) (50) "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)~~)) (51) "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)~~)) (52) "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)~~)) (53) "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)~~)) (54) "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)~~)) (55) "Resource utilization groups" means a case mix classification system that identifies relative resources needed to care for an individual nursing facility resident.

((~~(55)~~)) (56) "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.

1 ((~~(56)~~)) (57) "Seattle consumer price index" and "projected Seattle
2 consumer price index" means the most recently available actual or
3 projected percent change in the consumer price index for the
4 Seattle-Tacoma-Bremerton, Washington consolidated metropolitan
5 statistical area, as published by the Washington state economic and
6 revenue forecast council established under RCW 82.33.020.
7 (58) "Secretary" means the secretary of the department of social
8 and health services.
9 ((~~(57) "Support services" means food, food preparation, dietary,~~
10 ~~housekeeping, and laundry services provided to nursing facility~~
11 ~~residents.~~
12 ~~(58)~~)) (59) "Therapy care" means those services required by a
13 nursing facility resident's comprehensive assessment and plan of care,
14 that are provided by qualified therapists, or support personnel under
15 their supervision, including related costs as designated by the
16 department.
17 ((~~(59)~~)) (60) "Title XIX" or "medicaid" means the 1965 amendments
18 to the social security act, P.L. 89-07, as amended and the medicaid
19 program administered by the department.
20 ((~~(60)~~)) (61) "Urban county" means a county which is located in a
21 metropolitan statistical area as determined and defined by the United
22 States office of management and budget or other appropriate agency or
23 office of the federal government.
24 ((~~(61) "Vital local provider" means a facility reporting a home~~
25 ~~office that meets the following qualifications:~~
26 ~~(a) The home office address is located in Washington state; and~~
27 ~~(b) The sum of medicaid days for all Washington facilities~~
28 ~~reporting the home office as their home office was greater than two~~
29 ~~hundred fifteen thousand in 2003.~~))

30 **Sec. 2.** RCW 74.46.165 and 2001 1st sp.s. c 8 s 2 are each amended
31 to read as follows:
32 (1) Contractors shall be required to submit with each annual
33 nursing facility cost report a proposed settlement report showing
34 underspending or overspending in each component rate during the cost
35 report year on a per-resident day basis. The department shall accept
36 or reject the proposed settlement report, explain any adjustments, and
37 issue a revised settlement report if needed.

(2) Contractors shall not be required to refund payments made in the operations, variable return, property, and financing allowance component rates in excess of the adjusted costs of providing services corresponding to these components.

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

(4) Determination of unused rate funds, including the amounts of direct care, therapy care, and support services to be recovered, shall be done separately for each component rate, and, except as otherwise provided in this subsection, neither costs nor rate payments shall be shifted from one component rate or corresponding service area to another in determining the degree of underspending or recovery, if any. In computing a preliminary or final settlement, savings in the support services cost center shall be shifted to cover a deficit in the direct care or therapy cost centers up to the amount of any savings, but no more than twenty percent of the support services component rate may be shifted. In computing a preliminary or final settlement, savings in direct care and therapy care may be shifted to cover a deficit in these two cost centers up to the amount of savings in each, regardless of the percentage of either component rate shifted. Contractor-retained overpayments up to one percent of direct care, therapy care, and support services rate components, as authorized in subsection (3) of this section, shall be calculated and applied after all shifting is completed.

(5) Total and component payment rates assigned to a nursing facility, as calculated and revised, if needed, under the provisions of this chapter and those rules as the department may adopt, shall represent the maximum payment for nursing facility services rendered to medicaid recipients for the period the rates are in effect. No increase in payment to a contractor shall result from spending above the total payment rate or in any rate component.

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

(7) For calendar year ((~~1998~~)) 2007, the department shall calculate split settlements covering January 1, ((~~1998~~)) 2007, through ((~~September~~)) June 30, ((~~1998~~)) 2007, and ((~~October~~)) July 1, ((~~1998~~)) 2007, through December 31, ((~~1998~~)) 2007. ((~~For the period beginning October 1, 1998, rules specified in this chapter shall apply.~~)) The department shall use the provisions of this section for the January 1, 2007, through June 30, 2007, settlement. The provisions of this section shall not apply to rate settings or costs occurring July 1, 2007, or later. The department shall, by rule, determine the division of calendar year ((~~1998~~)) 2007 adjusted costs for settlement purposes.

(8) This section expires December 31, 2008.

NEW SECTION. **Sec. 3.** A new section is added to chapter 74.46 RCW to read as follows:

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

(2) Contractors shall not be required to refund payments made in the operations, capital, and disproportionate medicaid component rates in excess of the adjusted costs of providing services corresponding to these components.

(3) The facility shall return to the department any overpayment amounts in each of the direct care one and direct care two component rates that the department identifies following the audit and settlement

procedures as described in this chapter, provided that the contractor may retain any overpayment that does not exceed one percent of the facility's direct care one and direct care two component rates. Facilities that are not in substantial compliance for more than ninety days, and facilities that provide substandard quality of care at any time, during the period for which settlement is being calculated, will not be allowed to retain any amount of overpayment in the facility's direct care one and direct care two component rates. The terms "not in substantial compliance" and "substandard quality of care" shall be defined by federal survey regulations.

(4) Determination of unused rate funds, including the amounts of direct care one and direct care two to be recovered, shall be done separately for each component rate and neither costs nor rate payments shall be shifted from one component rate or corresponding service area to another in determining the degree of underspending or recovery, if any.

(5) Total and component payment rates assigned to a nursing facility, as calculated and revised, if needed, under the provisions of this chapter and those rules as the department may adopt, shall represent the maximum payment for nursing facility services rendered to medicaid recipients for the period the rates are in effect. No increase in payment to a contractor shall result from spending above the total payment rate or in any component rate.

(6) RCW 74.46.165 and rules adopted by the department prior to July 1, 2007, shall continue to govern the medicaid settlement process for periods prior to July 1, 2007, as if these statutes and rules remained in full force and effect.

(7) For calendar year 2007, the department shall calculate split settlements covering January 1, 2007, through June 30, 2007, and July 1, 2007, through December 31, 2007, under the provisions of this section and RCW 74.46.165. The department shall, by rule, determine the division of calendar year 2007 adjusted costs for settlement purposes.

Sec. 4. 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 direct care component rate allocations.

(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).

(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 therapy care component rate allocations.

(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 support services component rate allocations.

(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 operations component rate allocations.

(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.

1 (15) This section expires July 1, 2007.

2 NEW SECTION. **Sec. 5.** A new section is added to chapter 74.46 RCW
3 to read as follows:
4 (1) Effective July 1, 2007, nursing facility medicaid payment rate
5 allocations shall be facility-specific and shall have five components:
6 (a) Direct care one, (b) direct care two, (c) operations, (d) capital,
7 and (e) disproportionate medicaid. The department shall establish and
8 adjust each of these components, as provided in this section and
9 elsewhere in this chapter, for each medicaid nursing facility in this
10 state.
11 (2) Direct care one, direct care two, and operations component rate
12 allocations shall be established using adjusted cost report data
13 covering at least six months. Effective July 1, 2007, direct care one,
14 direct care two, and operations component rate allocations shall be
15 established using 2005 cost report data. The direct care one, direct
16 care two, and operations component rate allocations shall be rebased
17 biennially, so that effective July 1st of each odd year following 2007,
18 the direct care one, direct care two, and operations component rate
19 allocations shall be established using cost report data from the
20 preceding odd calendar year. For example, 2007 costs shall be used for
21 direct care one, direct care two, and operations component rate
22 allocations beginning July 1, 2009, and so forth.
23 (3) Direct care one, direct care two, and operations component rate
24 allocations shall be adjusted for economic trends and conditions by
25 five and one-quarter percent for the July 1, 2007, rate setting, and by
26 an additional three percent for the July 1, 2008, rate setting. Direct
27 care one, direct care two, and operations component rate allocations
28 shall be adjusted annually for economic trends and conditions by the
29 following factors in future years:
30 (a) For the July 1, 2009, rate setting, and for each rate setting
31 July 1st of subsequent odd-numbered years, the factor shall be set at:
32 (i) The sum of the projected Seattle consumer price index from the
33 midpoint of the cost year to the midpoint of the rate year. For
34 example, the factor used for the July 1, 2009, rate setting would be
35 the sum of half of the 2007 Seattle consumer price index, plus the
36 projected 2008 Seattle consumer price index, plus the projected 2009
37 Seattle consumer price index; and so forth.

(ii) If the sum calculated in (a)(i) of this subsection is greater than six percent, the factor shall be six percent.

(iii) If the sum calculated in (a)(i) of this subsection is less than five percent, the factor shall be five percent.

(b) For the July 1, 2010, rate setting, and for each rate setting July 1st of subsequent even-numbered years, the factor shall be set at the amount calculated in (a) of this subsection added to:

(i) The projected Seattle consumer price index from the calendar year corresponding to the beginning of the rate year. For example, the calendar year 2010 projected Seattle consumer price index for the July 1, 2010, rate setting; and so forth.

(ii) If the factor calculated in (b)(i) of this subsection is greater than three percent, the factor shall be three percent.

(iii) If the factor calculated in (b)(ii) of this subsection is less than two percent, the factor shall be two percent.

(4) 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.

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

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

(7) 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.

(8) 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.

(9) 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. 6. RCW 74.46.433 and 2006 c 258 s 3 are each amended to read as follows:

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

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

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

facilities, and four percent shall be assigned to facilities in the lowest quartile, three percent to facilities in the next lowest quartile, two percent to facilities in the next highest quartile, and one percent to facilities in the highest quartile.

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

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

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

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

(3) This section expires July 1, 2007.

NEW SECTION. **Sec. 7.** A new section is added to chapter 74.46 RCW to read as follows:

(1) Effective July 1, 2007, the department shall establish for each medicaid nursing facility a disproportionate medicaid component rate allocation.

(2) The disproportionate medicaid array and percentage shall be assigned whenever rebasing of the direct care one, direct care two, and operations component rates is scheduled to occur.

(3) The disproportionate medicaid component rate allocation shall be determined as follows:

(a) To calculate the array of facilities, the department, without using peer groups, shall first rank all facilities in numerical order from highest to lowest according to each facility's medicaid census from the rebase year. The array shall then be divided into four quartiles, each containing, as nearly as possible, an equal number of facilities, and four percent shall be assigned to facilities in the highest quartile, three percent to facilities in the next highest quartile, two percent to facilities in the next lowest quartile, and one percent to facilities in the lowest quartile.

(b) The department shall compute the disproportionate medicaid component rate by multiplying a facility's assigned percentage calculated in this subsection (3)(b) by the sum of the facility's direct care one, direct care two, and operations component rates determined in accordance with this chapter and rules adopted by the department.

(4) The disproportionate medicaid rate allocation calculated in accordance with this section shall be adjusted to the extent necessary to comply with RCW 74.46.421.

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

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

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

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

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

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

(6) This section expires July 1, 2007.

Sec. 9. RCW 74.46.437 and 2001 1st sp.s. c 8 s 8 are each amended to read as follows:

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

(2) Effective July 1, 2001, the financing allowance shall be determined by multiplying the net invested funds of each facility by .10, and dividing by the greater of a nursing facility's total resident days from the most recent cost report period or resident days calculated on eighty-five percent facility occupancy. Effective July 1, 2002, the financing allowance component rate allocation for all

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

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

1 is unable to provide necessary information to determine net invested
2 funds, the secretary shall have the authority to determine an amount
3 for net invested funds based on an appraisal conducted according to RCW
4 74.46.360(1).

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

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

21 (6) This section expires July 1, 2007.

22 NEW SECTION. **Sec. 10.** A new section is added to chapter 74.46 RCW
23 to read as follows:

24 (1) Effective July 1, 2007, the department shall establish for each
25 medicaid nursing facility a capital component rate allocation. The
26 capital component rate shall be rebased annually, effective July 1st,
27 in accordance with the provisions of this section and this chapter.

28 (2) The capital component rate allocation for each facility shall
29 be determined by:

30 (a) Summing the following:

31 (i) The sum of the reported allowable prior period actual
32 depreciation, subject to RCW 74.46.310 through 74.46.380, adjusted for
33 any capitalized additions or replacements approved by the department,
34 and the retained savings from such cost center;

35 (ii) For net invested funds acquired prior to May 17, 1999, and for
36 net invested funds pertaining to new construction or major renovations
37 receiving certificate of need approval or an exemption from certificate

of need requirements under chapter 70.38 RCW, and for working drawings that have been submitted to the department of health for construction review approval, prior to May 17, 1999, the facility's net invested funds multiplied by .10;

(iii) For net invested funds acquired on or after May 17, 1999 and not otherwise included in (a)(ii) of this subsection, the facility's net invested funds multiplied by .085;

(iv) The sum of reported real estate, personal property, and business and occupation taxes. Any taxes paid as a quality maintenance fee under RCW 82.71.020 shall not be included in this sum;

(b) Dividing the sum calculated in (a) of this subsection by the facility's actual resident days. If a capitalized addition or retirement of an asset will result in a different licensed bed capacity during the ensuing period, the prior period total resident days used in computing the property component rate shall be adjusted to anticipated resident day level.

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

(4) When a certificate of need for a new facility is requested, the department, in reaching its decision, shall take into consideration per

bed land and building construction costs for the facility which shall not exceed a maximum to be established by the secretary.

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

Sec. 11. RCW 74.46.439 and 1999 c 353 s 12 are each amended to read as follows:

(1) In the case of a facility that was leased by the contractor as of January 1, 1980, in an arm's-length agreement, which continues to be leased under the same lease agreement, and for which the annualized lease payment, plus any interest and depreciation expenses associated with contractor-owned assets, for the period covered by the prospective rates, divided by the contractor's total resident days, minus the property component rate allocation, is more than the sum of the financing allowance and the variable return rate determined according to this chapter, the following shall apply:

(a) The financing allowance shall be recomputed substituting the fair market value of the assets as of January 1, 1982, as determined by the department of general administration through an appraisal procedure, less accumulated depreciation on the lessor's assets since January 1, 1982, for the net book value of the assets in determining net invested funds for the facility. A determination by the department of general administration of fair market value shall be final unless the procedure used to make such a determination is shown to be arbitrary and capricious.

(b) The sum of the financing allowance computed under (a) of this subsection and the variable return rate shall be compared to the annualized lease payment, plus any interest and depreciation associated with contractor-owned assets, for the period covered by the prospective rates, divided by the contractor's total resident days, minus the property component rate. The lesser of the two amounts shall be called the alternate return on investment rate.

(c) The sum of the financing allowance and variable return rate determined according to this chapter or the alternate return on investment rate, whichever is greater, shall be added to the prospective rates of the contractor.

1 (2) In the case of a facility that was leased by the contractor as
2 of January 1, 1980, in an arm's-length agreement, if the lease is
3 renewed or extended under a provision of the lease, the treatment
4 provided in subsection (1) of this section shall be applied, except
5 that in the case of renewals or extensions made subsequent to April 1,
6 1985, reimbursement for the annualized lease payment shall be no
7 greater than the reimbursement for the annualized lease payment for the
8 last year prior to the renewal or extension of the lease.
9 (3) The alternate return on investment component rate allocations
10 calculated in accordance with this section shall be adjusted to the
11 extent necessary to comply with RCW 74.46.421.
12 (4) This section expires July 1, 2007.

13 **Sec. 12.** RCW 74.46.496 and 2006 c 258 s 4 are each amended to read
14 as follows:
15 (1) Each case mix classification group shall be assigned a case mix
16 weight. The case mix weight for each resident of a nursing facility
17 for each calendar quarter shall be based on data from resident
18 assessment instruments completed for the resident and weighted by the
19 number of days the resident was in each case mix classification group.
20 Days shall be counted as provided in this section.
21 (2) The case mix weights shall be based on the average minutes per
22 registered nurse, licensed practical nurse, and certified nurse aide,
23 for each case mix group, and using the health care financing
24 administration of the United States department of health and human
25 services 1995 nursing facility staff time measurement study stemming
26 from its multistate nursing home case mix and quality demonstration
27 project. Those minutes shall be weighted by statewide ratios of
28 registered nurse to certified nurse aide, and licensed practical nurse
29 to certified nurse aide, wages, including salaries and benefits, which
30 shall be based on 1995 cost report data for this state.
31 (3) The case mix weights shall be determined as follows:
32 (a) Set the certified nurse aide wage weight at 1.000 and calculate
33 wage weights for registered nurse and licensed practical nurse average
34 wages by dividing the certified nurse aide average wage into the
35 registered nurse average wage and licensed practical nurse average
36 wage;

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

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

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

(5) Case mix weights shall be revised when direct care one component rates are cost-rebased as provided in ((~~RCW 74.46.431(4)~~)) section 5(2) of this act.

Sec. 13. RCW 74.46.501 and 2006 c 258 s 5 are each amended to read as follows:

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

(2)(a) In calculating a facility's two average case mix indexes for each quarter, the department shall include all residents or medicaid residents, as applicable, who were physically in the facility during the quarter in question based on the resident assessment instrument completed by the facility and the requirements and limitations for the

instrument's completion and transmission (January 1st through March 31st, April 1st through June 30th, July 1st through September 30th, or October 1st through December 31st).

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

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

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

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

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

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

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

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

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

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

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

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

(6) A threshold of ninety percent, as described and calculated in this subsection, shall be used to determine the case mix index each quarter. The threshold shall also be used to determine which facilities' costs per case mix unit are included in determining the ceiling, floor, and price. ((~~For direct care component rate allocations established on and after July 1, 2006,~~)) The threshold of ninety percent shall be used to determine the case mix index each quarter and to determine which facilities' costs per case mix unit are included in determining the ceiling and price. If the facility does not meet the ninety percent threshold, the department may use an alternate case mix index to determine the facility average and medicaid average case mix indexes for the quarter. The threshold is a count of unique minimum data set assessments, and it shall include resident assessment instrument tracking forms for residents discharged prior to completing an initial assessment. The threshold is calculated by dividing a facility's count of residents being assessed by the average census for the facility. A daily census shall be reported by each nursing facility as it transmits assessment data to the department. The department shall compute a quarterly average census based on the daily census. If no census has been reported by a facility during a specified quarter, then the department shall use the facility's licensed beds as the denominator in computing the threshold.

(7)(a) Although the facility average and the medicaid average case mix indexes shall both be calculated quarterly, the facility average case mix index will be used throughout the applicable cost-rebasing period in combination with cost report data as specified by ((~~RCW 74.46.431~~)) section 5 of this act and RCW 74.46.506, to establish a facility's allowable cost per case mix unit. A facility's medicaid average case mix index shall be used to update a nursing facility's direct care one component rate quarterly.

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

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

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

~~(iii)~~)) Beginning on July 1, 2006, when establishing the direct care one component rates, the department shall use an average of facility case mix indexes from the four calendar quarters occurring during the cost report period used to rebase the direct care component rate allocations as specified in ((~~RCW 74.46.431~~)) section 5 of this act.

(c) The medicaid average case mix index used to update or recalibrate a nursing facility's direct care one component rate quarterly shall be from the calendar quarter commencing six months prior to the effective date of the quarterly rate. For example, ((~~October~~)) July 1, ((~~1998~~)) 2007, through ((~~December 31, 1998~~)) September 30, 2007, direct care component rates shall utilize case mix averages from the ((~~April~~)) January 1, ((~~1998~~)) 2007, through ((~~June~~)) March 30, ((~~1998~~)) 2007, calendar quarter, and so forth.

Sec. 14. 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 one 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 one 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 one 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

1 facility's assigned cost per case mix unit multiplied by that
2 facility's medicaid average case mix index from the applicable quarter
3 specified in RCW 74.46.501(7)(c);
4 (iii) Any facility whose allowable cost per case mix unit is
5 between eighty-five and one hundred fifteen percent of the peer group
6 median established under (f) of this subsection shall have a direct
7 care component rate allocation equal to the facility's allowable cost
8 per case mix unit multiplied by that facility's medicaid average case
9 mix index from the applicable quarter specified in RCW 74.46.501(7)(c);
10 (h) Except as provided in (i) of this subsection, from July 1,
11 2000, through June 30, 2006, determine each facility's quarterly direct
12 care component rate as follows:
13 (i) Any facility whose allowable cost per case mix unit is less
14 than ninety percent of the facility's peer group median established
15 under (f) of this subsection shall be assigned a cost per case mix unit
16 equal to ninety percent of the facility's peer group median, and shall
17 have a direct care component rate allocation equal to the facility's
18 assigned cost per case mix unit multiplied by that facility's medicaid
19 average case mix index from the applicable quarter specified in RCW
20 74.46.501(7)(c);
21 (ii) Any facility whose allowable cost per case mix unit is greater
22 than one hundred ten percent of the peer group median established under
23 (f) of this subsection shall be assigned a cost per case mix unit equal
24 to one hundred ten percent of the peer group median, and shall have a
25 direct care component rate allocation equal to the facility's assigned
26 cost per case mix unit multiplied by that facility's medicaid average
27 case mix index from the applicable quarter specified in RCW
28 74.46.501(7)(c);
29 (iii) Any facility whose allowable cost per case mix unit is
30 between ninety and one hundred ten percent of the peer group median
31 established under (f) of this subsection shall have a direct care
32 component rate allocation equal to the facility's allowable cost per
33 case mix unit multiplied by that facility's medicaid average case mix
34 index from the applicable quarter specified in RCW 74.46.501(7)(c);
35 (i)(i) Between October 1, 1998, and June 30, 2000, the department
36 shall compare each facility's direct care component rate allocation
37 calculated under (g) of this subsection with the facility's nursing
38 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, 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.

(8) This section expires July 1, 2007.

NEW SECTION. **Sec. 15.** A new section is added to chapter 74.46 RCW to read as follows:

(1) Effective July 1, 2007, the department shall establish for each medicaid nursing facility a direct care one component rate allocation. The direct care one component rate allocation corresponds to the provision of nursing care for one resident of a nursing facility for one day, and includes only costs associated with hours of care provided

1 by nurses and nurse aides. The direct care one component rate includes
2 elements of case mix determined consistent with the principles of this
3 section and other applicable provisions of this chapter.
4 (2) The department shall determine and update quarterly for each
5 nursing facility serving medicaid residents a facility-specific per
6 resident day direct care one component rate allocation, to be effective
7 on the first day of each calendar quarter. In determining direct care
8 one component rates the department shall utilize, as specified in this
9 section, minimum data set resident assessment data for each resident of
10 the facility, as transmitted to, and if necessary corrected by, the
11 department in the resident assessment instrument format approved by
12 federal authorities for use in this state.
13 (3) The department may question the accuracy of assessment data for
14 any resident and utilize corrected or substitute information, however
15 derived, in determining direct care one component rates. The
16 department is authorized to impose civil fines and to take adverse rate
17 actions against a contractor, as specified by the department in rule,
18 in order to obtain compliance with resident assessment and data
19 transmission requirements and to ensure accuracy.
20 (4) Cost report data used in setting direct care one component rate
21 allocations shall be as specified in section 5(2) of this act.
22 (5) The department shall rebase each nursing facility's direct care
23 one component rate allocation biennially as specified in section 5(2)
24 of this act, adjust its direct care one component rate allocation for
25 economic trends and conditions as described in section 5(3) of this
26 act, and update its medicaid average case mix index, consistent with
27 the following:
28 (a) Reduce total direct care one costs reported by each nursing
29 facility for the applicable cost report period specified in section
30 5(2) of this act to reflect any department adjustments, in order to
31 derive the facility's total allowable direct care one cost;
32 (b) Divide each facility's total allowable direct care one cost by
33 its adjusted resident days for the same report period;
34 (c) Adjust the facility's per resident day direct care one cost by
35 the economic trends and conditions factor established under section
36 5(2) of this act to derive its adjusted allowable direct care cost per
37 resident day;

1 (d) Divide each facility's adjusted allowable direct care one cost
2 per resident day by the facility average case mix index for the
3 applicable quarters specified by RCW 74.46.501(7)(b) to derive the
4 facility's allowable direct care cost per case mix unit;
5 (e) Divide nursing facilities into at least two and, if applicable,
6 three peer groups: (i) Those located in nonurban counties; (ii) those
7 located in high labor-cost counties, if any; and (iii) those located in
8 other urban counties;
9 (f) Array separately the allowable direct care one cost per case
10 mix unit for all facilities in nonurban counties; for all facilities in
11 high labor-cost counties, if applicable; and for all facilities in
12 other urban counties, and determine the median allowable direct care
13 cost per case mix unit for each peer group;
14 (g) Determine each facility's quarterly direct care one component
15 rate as follows:
16 (i) Any facility whose allowable cost per case mix unit is greater
17 than one hundred twelve percent of the peer group median established
18 under (f) of this subsection shall be assigned a cost per case mix unit
19 equal to one hundred twelve percent of the peer group median, and shall
20 have a direct care component rate allocation equal to the facility's
21 assigned cost per case mix unit multiplied by that facility's medicaid
22 average case mix index from the applicable quarter specified in RCW
23 74.46.501(7)(c);
24 (ii) Any facility whose allowable cost per case mix unit is less
25 than or equal to one hundred twelve percent of the peer group median
26 established under (f) of this subsection shall have a direct care one
27 component rate allocation equal to the facility's allowable cost per
28 case mix unit multiplied by that facility's medicaid average case mix
29 index from the applicable quarter specified in RCW 74.46.501(7)(c).
30 (6) The direct care one component rate allocations calculated in
31 accordance with this section shall be adjusted to the extent necessary
32 to comply with RCW 74.46.421.
33 (7) Costs related to payments resulting from increases in direct
34 care one component rates, granted under authority of RCW 74.46.508(1)
35 for a facility's exceptional care residents or section 16 of this act,
36 shall be offset against the facility's examined, allowable direct care
37 one costs, for each report year or partial period such increases are

paid. Such reductions in allowable direct care one costs shall be for rate setting, settlement, and other purposes deemed appropriate by the department.

NEW SECTION. **Sec. 16.** A new section is added to chapter 74.46 RCW to read as follows:

(1) The department shall grant an add-on to the direct care one component rate allocation for nursing facilities meeting the following criteria:

(a) For the July 1, 2007, rate setting, the nursing facility's direct care one cost per case mix unit, as established in section 15 of this act, is less than one hundred twelve percent of the median cost per case mix unit for that facility's direct care one peer group; and

(b) The nursing facility's medicaid census was sixty percent or greater in calendar year 2005.

(2) The amount of the add-on shall be calculated in the following manner:

(a) Determine the difference between the facility's direct care one cost per case mix unit and the cost per case mix unit set at one hundred twelve percent of the median for that facility's direct care one peer group, as of the July 1, 2007, rate setting; and

(b) Multiply the difference determined in (a) of this subsection by the facility's medicaid case mix score as of July 1, 2007; and

(c) Multiply the product determined in (b) of this subsection by fifty percent; and

(d) Multiply the product determined in (c) of this subsection by the facility's medicaid census for the calendar year 2005.

(3) The amount of the add-on granted in this section shall be added to the facility's direct care one rate, and the direct care one rate including the add-on shall be subject to the settlement process established in section 3 of this act.

(4) This section expires July 1, 2011.

Sec. 17. RCW 74.46.508 and 2003 1st sp.s. c 6 s 1 are each amended to read as follows:

(1) The department is authorized to increase the direct care one and direct care two component rate allocations calculated under ((~~RCW 74.46.506(5)~~)) this chapter for residents who have unmet exceptional

care needs as determined by the department in rule. The department may, by rule, establish criteria, patient categories, and methods of exceptional care payment.

(2) The department may by July 1, 2003, adopt rules and implement a system of exceptional care payments for therapy care.

(a) Payments may be made on behalf of facility residents who are under age sixty-five, not eligible for medicare, and can achieve significant progress in their functional status if provided with intensive therapy care services.

(b) Payments may be made only after approval of a rehabilitation plan of care for each resident on whose behalf a payment is made under this subsection, and each resident's progress must be periodically monitored.

Sec. 18. RCW 74.46.511 and 2001 1st sp.s. c 8 s 11 are each amended to read as follows:

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

(8) This section expires July 1, 2007.

Sec. 19. RCW 74.46.515 and 2001 1st sp.s. c 8 s 12 are each amended to read as follows:

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

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

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

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

(b) Set each facility's support services component rate at the lower of the facility's per resident day adjusted support services costs from the applicable cost report period or the adjusted median per resident day support services cost for that facility's peer group, either urban counties or nonurban counties, plus ten percent; and

1 (c) Adjust each facility's support services component rate for
2 economic trends and conditions as provided in RCW 74.46.431(6).
3 (4) The support services component rate allocations calculated in
4 accordance with this section shall be adjusted to the extent necessary
5 to comply with RCW 74.46.421.
6 <u>(5) This section expires July 1, 2007.</u>

7 <u>NEW SECTION.</u> **Sec. 20.** A new section is added to chapter 74.46 RCW
8 to read as follows:
9 (1) Effective July 1, 2007, the department shall establish for each
10 medicaid nursing facility a direct care two component rate allocation.
11 The direct care two component rate allocation corresponds to the
12 provision of food, food preparation, dietary, housekeeping, laundry
13 services, therapy, and nursing-related services not included in direct
14 care one for one resident for one day. For the direct care two
15 component rate allocation, therapy corresponds to the provision of
16 medicaid one-on-one therapy provided by a qualified therapist as
17 defined in this chapter, including therapy supplies and therapy
18 consultation.
19 (2) The department shall determine each medicaid nursing facility's
20 direct care two component rate allocation using cost report data as
21 specified in section 5 of this act.
22 (3) To determine each facility's direct care two component rate
23 allocation, the department shall:
24 (a) Array facilities' adjusted direct care two costs per adjusted
25 resident day for each facility from facilities' cost reports from the
26 applicable report year, for facilities located within urban counties,
27 for those located within nonurban counties, and for those located in
28 high labor-cost counties, if any, and determine the median adjusted
29 cost per adjusted resident day for each peer group;
30 (b) Set each facility's direct care two component rate at the lower
31 of the facility's per resident day adjusted direct care two costs from
32 the applicable cost report period or the adjusted median per resident
33 day direct care two cost for that facility's peer group, either urban
34 counties or nonurban counties, plus twelve percent; and
35 (c) Adjust each facility's direct care two component rate for
36 economic trends and conditions as provided in section 5 of this act.

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

4 NEW SECTION. **Sec. 21.** A new section is added to chapter 74.46 RCW
5 to read as follows:
6 (1) The department shall grant an add-on to the direct care two
7 component rate allocation for nursing facilities meeting the following
8 criteria:
9 (a) For the July 1, 2007, rate setting, the nursing facility's
10 direct care two costs per resident day, as established in this chapter,
11 are less than one hundred twelve percent of the median costs per
12 resident day for that facility's direct care two peer group; and
13 (b) The nursing facility's medicaid census was sixty percent or
14 greater in calendar year 2005.
15 (2) The amount of the add-on shall be calculated in the following
16 manner:
17 (a) Determine the difference between the facility's July 1, 2007,
18 direct care two costs per resident day and the costs per resident day
19 set at one hundred twelve percent of the median for that facility's
20 direct care two peer group, as of the July 1, 2007, rate setting; and
21 (b) Multiply the product determined in (a) of this subsection by
22 fifty percent; and
23 (c) Multiply the product determined in (b) of this subsection by
24 the facility's medicaid census for the calendar year 2005.
25 (3) The amount of the add-on granted in this section shall be added
26 to the facility's direct care two rate, and the direct care two rate
27 including the add-on shall be subject to the settlement process
28 established in section 3 of this act.
29 (4) This section expires July 1, 2011.

30 **Sec. 22.** RCW 74.46.521 and 2006 c 258 s 7 are each amended to read
31 as follows:
32 (1) The operations component rate allocation corresponds to the
33 general operation of a nursing facility for one resident for one day,
34 including but not limited to management, administration, utilities,
35 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, 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.

(6) This section expires July 1, 2007.

NEW SECTION. **Sec. 23.** A new section is added to chapter 74.46 RCW to read as follows:

(1) Effective July 1, 2007, the department shall establish for each medicaid nursing facility an operations component rate allocation. 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 one, direct care two, and capital. The operations component rate allocation does not include the costs of the quality maintenance fee established under RCW 82.71.020, nor shall such costs be included in any of the component rate allocations under this chapter.

(2) The department shall determine each medicaid nursing facility's operations component rate allocation using cost report data specified in section 5 of this act.

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

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

(b) Set each facility's operations component rate at the lower of the facility's per resident day adjusted operations costs from the applicable cost report period or the adjusted median per resident day

support services cost for that facility's peer group, either urban or nonurban counties, or high labor-cost counties, plus seven percent; and

(c) Adjust each facility's operations component rate for economic trends and conditions as provided in section 5 of this act.

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

NEW SECTION. **Sec. 24.** Except for section 2 of this act, 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.

--- END ---