
SUBSTITUTE HOUSE BILL 3202

State of Washington 61st Legislature 2010 Regular Session

By House Ways & Means (originally sponsored by Representative Cody)

READ FIRST TIME 03/09/10.

1 AN ACT Relating to revising the medicaid nursing facility payment
2 system by moving rebasing to even years, changing the case mix
3 adjustment cycle to six months, establishing pay for performance,
4 adjusting rates based upon rates of direct care staff turnover, and
5 modifying components related to variable return, operations, property,
6 and finance; amending RCW 74.46.431, 74.46.435, 74.46.437, 74.46.439,
7 74.46.496, 74.46.501, 74.46.506, and 74.46.521; adding a new section to
8 chapter 74.46 RCW; repealing RCW 74.46.433; and declaring an emergency.

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

10 **Sec. 1.** RCW 74.46.431 and 2009 c 570 s 1 are each amended to read
11 as follows:

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

1 (2) Component rate allocations in therapy care, support services,
2 (~~variable return~~) operations, property, and financing allowance for
3 essential community providers as defined in this chapter shall be based
4 upon a minimum facility occupancy of eighty-five percent of licensed
5 beds, regardless of how many beds are set up or in use. For all
6 facilities other than essential community providers, (~~effective July~~
7 ~~1, 2001~~) the component rate allocations in (~~direct care~~) therapy
8 care(~~)~~ and support services(~~, and variable return~~) shall be based
9 upon a minimum facility occupancy of eighty-five percent of licensed
10 beds. For (~~all~~) facilities other than essential community providers
11 that have set up or use sixty beds or fewer, (~~effective July 1,~~
12 ~~2002~~) the component rate allocations in operations, property, and
13 financing allowance shall be based upon a minimum facility occupancy of
14 ninety percent of licensed beds(~~, regardless of how many beds are set~~
15 ~~up or in use~~). For facilities other than essential community
16 providers that have set up or use more than sixty beds, the component
17 rate allocations in operations, property, and financing allowance shall
18 be based upon a minimum facility occupancy of ninety-two percent of
19 licensed beds. For all facilities, (~~effective July 1, 2006~~) the
20 component rate allocation in direct care shall be based upon actual
21 facility occupancy. The median cost limits used to set component rate
22 allocations shall be based on the applicable minimum occupancy
23 percentage. In determining each facility's therapy care component rate
24 allocation under RCW 74.46.511, the department shall apply the
25 applicable minimum facility occupancy adjustment before creating the
26 array of facilities' adjusted therapy costs per adjusted resident day.
27 In determining each facility's support services component rate
28 allocation under RCW 74.46.515(3), the department shall apply the
29 applicable minimum facility occupancy adjustment before creating the
30 array of facilities' adjusted support services costs per adjusted
31 resident day. In determining each facility's operations component rate
32 allocation under RCW 74.46.521(3), the department shall apply the
33 minimum facility occupancy adjustment before creating the array of
34 facilities' adjusted general operations costs per adjusted resident
35 day.

36 (3) Information and data sources used in determining medicaid
37 payment rate allocations, including formulas, procedures, cost report
38 periods, resident assessment instrument formats, resident assessment

1 methodologies, and resident classification and case mix weighting
2 methodologies, may be substituted or altered from time to time as
3 determined by the department.

4 (4)(a) Direct care component rate allocations shall be established
5 using adjusted cost report data covering at least six months.
6 (~~Adjusted cost report data from 1996 will be used for October 1, 1998,~~
7 ~~through June 30, 2001, direct care component rate allocations; adjusted~~
8 ~~cost report data from 1999 will be used for July 1, 2001, through June~~
9 ~~30, 2006, direct care component rate allocations. Adjusted cost report~~
10 ~~data from 2003 will be used for July 1, 2006, through June 30, 2007,~~
11 ~~direct care component rate allocations. Adjusted cost report data from~~
12 ~~2005 will be used for July 1, 2007, through June 30, 2009, direct care~~
13 ~~component rate allocations.)) Effective July 1, 2009, the direct care~~
14 ~~component rate allocation shall be rebased ((biennially, and thereafter~~
15 ~~for each odd-numbered year beginning July 1st)), using the adjusted~~
16 ~~cost report data for the calendar year two years immediately preceding~~
17 ~~the rate rebase period, so that adjusted cost report data for calendar~~
18 ~~year 2007 is used for July 1, 2009, through June 30, ((2011, and so~~
19 ~~forth.~~

20 ~~(b) Direct care component rate allocations based on 1996 cost~~
21 ~~report data shall be adjusted annually for economic trends and~~
22 ~~conditions by a factor or factors defined in the biennial~~
23 ~~appropriations act. A different economic trends and conditions~~
24 ~~adjustment factor or factors may be defined in the biennial~~
25 ~~appropriations act for facilities whose direct care component rate is~~
26 ~~set equal to their adjusted June 30, 1998, rate, as provided in RCW~~
27 ~~74.46.506(5)(i).~~

28 ~~(c) Direct care component rate allocations based on 1999 cost~~
29 ~~report data shall be adjusted annually for economic trends and~~
30 ~~conditions by a factor or factors defined in the biennial~~
31 ~~appropriations act. A different economic trends and conditions~~
32 ~~adjustment factor or factors may be defined in the biennial~~
33 ~~appropriations act for facilities whose direct care component rate is~~
34 ~~set equal to their adjusted June 30, 1998, rate, as provided in RCW~~
35 ~~74.46.506(5)(i).~~

36 ~~(d) Direct care component rate allocations based on 2003 cost~~
37 ~~report data shall be adjusted annually for economic trends and~~
38 ~~conditions by a factor or factors defined in the biennial~~

1 ~~appropriations act. A different economic trends and conditions~~
2 ~~adjustment factor or factors may be defined in the biennial~~
3 ~~appropriations act for facilities whose direct care component rate is~~
4 ~~set equal to their adjusted June 30, 2006, rate, as provided in RCW~~
5 ~~74.46.506(5)(i).~~

6 (e)) 2012. Beginning July 1, 2012, the direct care component rate
7 allocation shall be rebased biennially during every even-numbered year
8 thereafter using adjusted cost report data from two years prior to the
9 rebase period, so adjusted cost report data for calendar year 2010 is
10 used for July 1, 2012, through June 30, 2014, and so forth.

11 (b) Direct care component rate allocations established in
12 accordance with this chapter shall be adjusted annually for economic
13 trends and conditions by a factor or factors defined in the biennial
14 appropriations act. The economic trends and conditions factor or
15 factors defined in the biennial appropriations act shall not be
16 compounded with the economic trends and conditions factor or factors
17 defined in any other biennial appropriations acts before applying it to
18 the direct care component rate allocation established in accordance
19 with this chapter. When no economic trends and conditions factor or
20 factors for either fiscal year are defined in a biennial appropriations
21 act, no economic trends and conditions factor or factors defined in any
22 earlier biennial appropriations act shall be applied solely or
23 compounded to the direct care component rate allocation established in
24 accordance with this chapter.

25 (5)(a) Therapy care component rate allocations shall be established
26 using adjusted cost report data covering at least six months.
27 ~~((Adjusted cost report data from 1996 will be used for October 1, 1998,~~
28 ~~through June 30, 2001, therapy care component rate allocations;~~
29 ~~adjusted cost report data from 1999 will be used for July 1, 2001,~~
30 ~~through June 30, 2005, therapy care component rate allocations.~~
31 ~~Adjusted cost report data from 1999 will continue to be used for July~~
32 ~~1, 2005, through June 30, 2007, therapy care component rate~~
33 ~~allocations. Adjusted cost report data from 2005 will be used for July~~
34 ~~1, 2007, through June 30, 2009, therapy care component rate~~
35 ~~allocations.))~~ Effective July 1, 2009, ~~((and thereafter for each~~
36 ~~odd-numbered year beginning July 1st,))~~ the therapy care component rate
37 allocation shall be cost rebased biennially, using the adjusted cost
38 report data for the calendar year two years immediately preceding the

1 rate rebase period, so that adjusted cost report data for calendar year
2 2007 is used for July 1, 2009, through June 30, ~~((2011))~~ 2012.
3 Beginning July 1, 2012, the therapy care component rate allocation
4 shall be rebased biennially during every even-numbered year thereafter
5 using adjusted cost report data from two years prior to the rebase
6 period, so adjusted cost report data for calendar year 2010 is used for
7 July 1, 2012, through June 30, 2014, and so forth.

8 (b) Therapy care component rate allocations established in
9 accordance with this chapter shall be adjusted annually for economic
10 trends and conditions by a factor or factors defined in the biennial
11 appropriations act. The economic trends and conditions factor or
12 factors defined in the biennial appropriations act shall not be
13 compounded with the economic trends and conditions factor or factors
14 defined in any other biennial appropriations acts before applying it to
15 the therapy care component rate allocation established in accordance
16 with this chapter. When no economic trends and conditions factor or
17 factors for either fiscal year are defined in a biennial appropriations
18 act, no economic trends and conditions factor or factors defined in any
19 earlier biennial appropriations act shall be applied solely or
20 compounded to the therapy care component rate allocation established in
21 accordance with this chapter.

22 (6)(a) Support services component rate allocations shall be
23 established using adjusted cost report data covering at least six
24 months. ~~((Adjusted cost report data from 1996 shall be used for~~
25 ~~October 1, 1998, through June 30, 2001, support services component rate~~
26 ~~allocations; adjusted cost report data from 1999 shall be used for July~~
27 ~~1, 2001, through June 30, 2005, support services component rate~~
28 ~~allocations. Adjusted cost report data from 1999 will continue to be~~
29 ~~used for July 1, 2005, through June 30, 2007, support services~~
30 ~~component rate allocations. Adjusted cost report data from 2005 will~~
31 ~~be used for July 1, 2007, through June 30, 2009, support services~~
32 ~~component rate allocations.))~~ Effective July 1, 2009, ~~((and thereafter~~
33 ~~for each odd-numbered year beginning July 1st,))~~ the support services
34 component rate allocation shall be cost rebased biennially, using the
35 adjusted cost report data for the calendar year two years immediately
36 preceding the rate rebase period, so that adjusted cost report data for
37 calendar year 2007 is used for July 1, 2009, through June 30, ~~((2011))~~
38 2012. Beginning July 1, 2012, the support services component rate

1 allocation shall be rebased biennially during every even-numbered year
2 thereafter using adjusted cost report data from two years prior to the
3 rebase period, so adjusted cost report data for calendar year 2010 is
4 used for July 1, 2012, through June 30, 2014, and so forth.

5 (b) Support services component rate allocations established in
6 accordance with this chapter shall be adjusted annually for economic
7 trends and conditions by a factor or factors defined in the biennial
8 appropriations act. The economic trends and conditions factor or
9 factors defined in the biennial appropriations act shall not be
10 compounded with the economic trends and conditions factor or factors
11 defined in any other biennial appropriations acts before applying it to
12 the support services component rate allocation established in
13 accordance with this chapter. When no economic trends and conditions
14 factor or factors for either fiscal year are defined in a biennial
15 appropriations act, no economic trends and conditions factor or factors
16 defined in any earlier biennial appropriations act shall be applied
17 solely or compounded to the support services component rate allocation
18 established in accordance with this chapter.

19 (7)(a) Operations component rate allocations shall be established
20 using adjusted cost report data covering at least six months.
21 ~~((Adjusted cost report data from 1996 shall be used for October 1,~~
22 ~~1998, through June 30, 2001, operations component rate allocations;~~
23 ~~adjusted cost report data from 1999 shall be used for July 1, 2001,~~
24 ~~through June 30, 2006, operations component rate allocations. Adjusted~~
25 ~~cost report data from 2003 will be used for July 1, 2006, through June~~
26 ~~30, 2007, operations component rate allocations. Adjusted cost report~~
27 ~~data from 2005 will be used for July 1, 2007, through June 30, 2009,~~
28 ~~operations component rate allocations.))~~ Effective July 1, 2009, ~~((and~~
29 ~~thereafter for each odd-numbered year beginning July 1st,))~~ the
30 operations component rate allocation shall be cost rebased biennially,
31 using the adjusted cost report data for the calendar year two years
32 immediately preceding the rate rebase period, so that adjusted cost
33 report data for calendar year 2007 is used for July 1, 2009, through
34 June 30, ~~((2011))~~ 2012. Beginning July 1, 2012, the operations care
35 component rate allocation shall be rebased biennially during every
36 even-numbered year thereafter using adjusted cost report data from two
37 years prior to the rebase period, so adjusted cost report data for

1 calendar year 2010 is used for July 1, 2012, through June 30, 2014, and
2 so forth.

3 (b) Operations component rate allocations established in accordance
4 with this chapter shall be adjusted annually for economic trends and
5 conditions by a factor or factors defined in the biennial
6 appropriations act. The economic trends and conditions factor or
7 factors defined in the biennial appropriations act shall not be
8 compounded with the economic trends and conditions factor or factors
9 defined in any other biennial appropriations acts before applying it to
10 the operations component rate allocation established in accordance with
11 this chapter. When no economic trends and conditions factor or factors
12 for either fiscal year are defined in a biennial appropriations act, no
13 economic trends and conditions factor or factors defined in any earlier
14 biennial appropriations act shall be applied solely or compounded to
15 the operations component rate allocation established in accordance with
16 this chapter. ~~((A different economic trends and conditions adjustment~~
17 ~~factor or factors may be defined in the biennial appropriations act for~~
18 ~~facilities whose operations component rate is set equal to their~~
19 ~~adjusted June 30, 2006, rate, as provided in RCW 74.46.521(4)).~~

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

27 ~~(9))~~ (8) Total payment rates under the nursing facility medicaid
28 payment system shall not exceed facility rates charged to the general
29 public for comparable services.

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

33 ~~(11))~~ (9) The department shall establish in rule procedures,
34 principles, and conditions for determining component rate allocations
35 for facilities in circumstances not directly addressed by this chapter,
36 including but not limited to: ~~((The need to prorate))~~ Inflation
37 adjustments for partial-period cost report data, newly constructed
38 facilities, existing facilities entering the medicaid program for the

1 first time or after a period of absence from the program, existing
2 facilities with expanded new bed capacity, existing medicaid facilities
3 following a change of ownership of the nursing facility business,
4 (~~facilities banking beds or converting beds back into service,~~)
5 facilities temporarily reducing the number of set-up beds during a
6 remodel, facilities having less than six months of either resident
7 assessment, cost report data, or both, under the current contractor
8 prior to rate setting, and other circumstances.

9 ~~((12))~~ (10) The department shall establish in rule procedures,
10 principles, and conditions, including necessary threshold costs, for
11 adjusting rates to reflect capital improvements or new requirements
12 imposed by the department or the federal government. Any such rate
13 adjustments are subject to the provisions of RCW 74.46.421.

14 ~~((13) Effective July 1, 2001, medicaid rates shall continue to be
15 revised downward in all components, in accordance with department
16 rules, for facilities converting banked beds to active service under
17 chapter 70.38 RCW, by using the facility's increased licensed bed
18 capacity to recalculate minimum occupancy for rate setting. However,
19 for facilities other than essential community providers which bank beds
20 under chapter 70.38 RCW, after May 25, 2001, medicaid rates shall be
21 revised upward, in accordance with department rules, in direct care,
22 therapy care, support services, and variable return components only, by
23 using the facility's decreased licensed bed capacity to recalculate
24 minimum occupancy for rate setting, but no upward revision shall be
25 made to operations, property, or financing allowance component rates.
26 The direct care component rate allocation shall be adjusted, without
27 using the minimum occupancy assumption, for facilities that convert
28 banked beds to active service, under chapter 70.38 RCW, beginning on
29 July 1, 2006. Effective July 1, 2007, component rate allocations for
30 direct care shall be based on actual patient days regardless of whether
31 a facility has converted banked beds to active service.~~

32 ~~(14))~~ (11) Facilities obtaining a certificate of need or a
33 certificate of need exemption under chapter 70.38 RCW after June 30,
34 2001, must have a certificate of capital authorization in order for (a)
35 the depreciation resulting from the capitalized addition to be included
36 in calculation of the facility's property component rate allocation;
37 and (b) the net invested funds associated with the capitalized addition

1 to be included in calculation of the facility's financing allowance
2 rate allocation.

3 **Sec. 2.** RCW 74.46.435 and 2001 1st sp.s. c 8 s 7 are each amended
4 to read as follows:

5 (1) (~~Effective July 1, 2001,~~) The property component rate
6 allocation for each facility shall be determined by dividing the sum of
7 the reported allowable prior period actual depreciation, subject to
8 (~~RCW 74.46.310 through 74.46.380~~) department rule, adjusted for any
9 capitalized additions or replacements approved by the department, and
10 the retained savings from such cost center, by the greater of a
11 facility's total resident days for the facility in the prior period or
12 resident days as calculated on (~~eighty-five~~) ninety-two percent
13 facility occupancy for all providers except (a) essential community
14 providers and (b) nonessential community providers with sixty or fewer
15 beds. (~~Effective July 1, 2002, the property component rate allocation~~
16 ~~for all facilities, except essential community providers, shall be set~~
17 ~~by using the greater of a facility's total resident days from the most~~
18 ~~recent cost report period or resident days calculated at ninety percent~~
19 ~~facility occupancy.~~) If a capitalized addition or retirement of an
20 asset will result in a different licensed bed capacity during the
21 ensuing period, the prior period total resident days used in computing
22 the property component rate shall be adjusted to anticipated resident
23 day level.

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

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

31 (4) (~~Effective July 1, 2001, for the purpose of calculating a~~
32 ~~nursing facility's property component rate, if a contractor has elected~~
33 ~~to bank licensed beds prior to April 1, 2001, or elects to convert~~
34 ~~banked beds to active service at any time, under chapter 70.38 RCW, the~~
35 ~~department shall use the facility's new licensed bed capacity to~~
36 ~~recalculate minimum occupancy for rate setting and revise the property~~
37 ~~component rate, as needed, effective as of the date the beds are banked~~

1 ~~or converted to active service. However, in no case shall the~~
2 ~~department use less than eighty five percent occupancy of the~~
3 ~~facility's licensed bed capacity after banking or conversion.~~
4 ~~Effective July 1, 2002,))~~ In no case, other than essential community
5 providers or nonessential community providers with sixty beds or fewer,
6 shall the department use less than ninety percent occupancy of the
7 facility's licensed bed capacity (~~(after conversion)~~).

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

11 **Sec. 3.** RCW 74.46.437 and 2001 1st sp.s. c 8 s 8 are each amended
12 to read as follows:

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

18 (2) (~~Effective July 1, 2001,~~) The financing allowance shall be
19 determined by multiplying the net invested funds of each facility by
20 .10, and dividing by the greater of a nursing facility's total resident
21 days from the most recent cost report period or resident days
22 calculated on (~~(eighty five)~~) ninety-two percent facility occupancy for
23 all providers except (a) essential community providers and (b)
24 nonessential community providers with sixty or fewer beds. (~~Effective~~
25 ~~July 1, 2002, the financing allowance component rate allocation for all~~
26 ~~facilities, other than essential community providers, shall be set by~~
27 ~~using the greater of a facility's total resident days from the most~~
28 ~~recent cost report period or resident days calculated at ninety percent~~
29 ~~facility occupancy.)) However, assets acquired on or after May 17,~~
30 1999, shall be grouped in a separate financing allowance calculation
31 that shall be multiplied by (~~(.085)~~) .075. The financing allowance
32 factor of (~~(.085)~~) .075 shall not be applied to the net invested funds
33 pertaining to new construction or major renovations receiving
34 certificate of need approval or an exemption from certificate of need
35 requirements under chapter 70.38 RCW, or to working drawings that have
36 been submitted to the department of health for construction review
37 approval, prior to May 17, 1999. If a capitalized addition,

1 renovation, replacement, or retirement of an asset will result in a
2 different licensed bed capacity during the ensuing period, the prior
3 period total resident days used in computing the financing allowance
4 shall be adjusted to the greater of the anticipated resident day level
5 or ~~((eighty-five))~~ ninety-two percent of the new licensed bed capacity
6 for all providers except (a) essential community providers and (b)
7 nonessential community providers with sixty or fewer beds. Effective
8 July 1, 2002, for all facilities, other than essential community
9 providers and nonessential community providers with sixty or fewer
10 beds, the total resident days used to compute the financing allowance
11 after a capitalized addition, renovation, replacement, or retirement of
12 an asset shall be set by using the greater of a facility's total
13 resident days from the most recent cost report period or resident days
14 calculated at ninety-two percent facility occupancy.

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

34 (4) ~~((Effective July 1, 2001, for the purpose of calculating a~~
35 ~~nursing facility's financing allowance component rate, if a contractor~~
36 ~~has elected to bank licensed beds prior to May 25, 2001, or elects to~~
37 ~~convert banked beds to active service at any time, under chapter 70.38~~
38 ~~RCW, the department shall use the facility's new licensed bed capacity~~

1 ~~to recalculate minimum occupancy for rate setting and revise the~~
2 ~~financing allowance component rate, as needed, effective as of the date~~
3 ~~the beds are banked or converted to active service. However, in no~~
4 ~~case shall the department use less than eighty five percent occupancy~~
5 ~~of the facility's licensed bed capacity after banking or conversion.~~
6 ~~Effective July 1, 2002,))~~ In no case, other than for essential
7 community providers and nonessential community providers with sixty or
8 fewer beds, shall the department use less than ninety-two percent
9 occupancy of the facility's licensed bed capacity after conversion.

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

13 **Sec. 4.** RCW 74.46.439 and 1999 c 353 s 12 are each amended to read
14 as follows:

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

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

33 (b) ~~The sum of the financing allowance computed under (a) of this~~
34 ~~subsection and the variable return rate shall be compared to the~~
35 ~~annualized lease payment, plus any interest and depreciation associated~~
36 ~~with contractor owned assets, for the period covered by the prospective~~

1 rates, divided by the contractor's total resident days, minus the
2 property component rate. The lesser of the two amounts shall be called
3 the alternate return on investment rate.

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

8 (2) In the case of a facility that was leased by the contractor as
9 of January 1, 1980, in an arm's length agreement, if the lease is
10 renewed or extended under a provision of the lease, the treatment
11 provided in subsection (1) of this section shall be applied, except
12 that in the case of renewals or extensions made subsequent to April 1,
13 1985, reimbursement for the annualized lease payment shall be no
14 greater than the reimbursement for the annualized lease payment for the
15 last year prior to the renewal or extension of the lease.

16 (3)) the financing allowance rate will be the greater of the rate
17 existing on June 30, 2010, or the rate calculated under RCW 74.46.437.

18 (2) The alternate return on investment component rate allocations
19 calculated in accordance with this section shall be adjusted to the
20 extent necessary to comply with RCW 74.46.421.

21 **Sec. 5.** RCW 74.46.496 and 2006 c 258 s 4 are each amended to read
22 as follows:

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

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

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

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

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

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

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

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

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

34 **Sec. 6.** RCW 74.46.501 and 2006 c 258 s 5 are each amended to read
35 as follows:

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

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

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

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

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

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

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

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

35 ~~(iii) If a resident's significant change, quarterly, or annual~~
36 ~~assessment is not timely completed and transmitted to the department by~~
37 ~~the cutoff date under state and federal requirements and as described~~

1 ~~in subsection (5) of this section, the start date shall be the due date~~
2 ~~for the assessment.~~

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

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

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

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

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

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

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

1 an initial assessment. The threshold is calculated by dividing a
2 facility's count of residents being assessed by the average census for
3 the facility. A daily census shall be reported by each nursing
4 facility as it transmits assessment data to the department. The
5 department shall compute a quarterly average census based on the daily
6 census. If no census has been reported by a facility during a
7 specified quarter, then the department shall use the facility's
8 licensed beds as the denominator in computing the threshold.

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

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

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

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

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

32 (c) The medicaid average case mix index used to update or
33 recalibrate a nursing facility's direct care component rate
34 ((quarterly)) semiannually shall be from the calendar ((quarter)) six-
35 month period commencing ((six)) nine months prior to the effective date
36 of the ((quarterly)) semiannual rate. For example, ((October 1, 1998))
37 July 1, 2010, through December 31, ((1998)) 2010, direct care component

1 rates shall utilize case mix averages from the (~~April 1, 1998~~)
2 October 1, 2009, through (~~June 30, 1998~~) March 31, 2010, calendar
3 quarters, and so forth.

4 **Sec. 7.** RCW 74.46.506 and 2007 c 508 s 3 are each amended to read
5 as follows:

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

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

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

30 (4) Cost report data used in setting direct care component rate
31 allocations shall be for rate periods as specified in RCW
32 74.46.431(4)(a).

33 (5) (~~Beginning October 1, 1998,~~) The department shall rebase each
34 nursing facility's direct care component rate allocation as described
35 in RCW 74.46.431, adjust its direct care component rate allocation for
36 economic trends and conditions as described in RCW 74.46.431, and

1 update its medicaid average case mix index, consistent with the
2 following:

3 (a) ~~((Reduce))~~ Adjust total direct care costs reported by each
4 nursing facility for the applicable cost report period specified in RCW
5 74.46.431(4)(a) to reflect any department adjustments, and to eliminate
6 reported resident therapy costs and adjustments, in order to derive the
7 facility's total allowable direct care cost;

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

16 (c) ~~((Adjust the facility's per resident day direct care cost by
17 the applicable factor specified in RCW 74.46.431(4) to derive its
18 adjusted allowable direct care cost per resident day;~~

19 ~~((d))~~ Divide each facility's adjusted allowable direct care cost
20 per resident day by the facility average case mix index for the
21 applicable quarters specified by RCW 74.46.501~~((+7))~~ (6)(b) to derive
22 the facility's allowable direct care cost per case mix unit;

23 ~~((e) Effective for July 1, 2001, rate setting,))~~ (d) Divide
24 nursing facilities into at least two and, if applicable, three peer
25 groups: Those located in nonurban counties; those located in high
26 labor-cost counties, if any; and those located in other urban counties;

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

32 ~~((g) Except as provided in (i) of this subsection, from October 1,
33 1998, through June 30, 2000, determine each facility's quarterly direct
34 care component rate as follows:~~

35 ~~((i) Any facility whose allowable cost per case mix unit is less
36 than eighty five percent of the facility's peer group median
37 established under (f) of this subsection shall be assigned a cost per
38 case mix unit equal to eighty five percent of the facility's peer group~~

1 median, and shall have a direct care component rate allocation equal to
2 the facility's assigned cost per case mix unit multiplied by that
3 facility's medicaid average case mix index from the applicable quarter
4 specified in RCW 74.46.501(7)(c);

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

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

19 (h) Except as provided in (i) of this subsection, from July 1,
20 2000, through June 30, 2006, determine each facility's quarterly direct
21 care component rate as follows:

22 (i) Any facility whose allowable cost per case mix unit is less
23 than ninety percent of the facility's peer group median established
24 under (f) of this subsection shall be assigned a cost per case mix unit
25 equal to ninety percent of the facility's peer group median, and shall
26 have a direct care component rate allocation equal to the facility's
27 assigned cost per case mix unit multiplied by that facility's medicaid
28 average case mix index from the applicable quarter specified in RCW
29 74.46.501(7)(c);

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

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

7 ~~(i)(i) Between October 1, 1998, and June 30, 2000, the department~~
8 ~~shall compare each facility's direct care component rate allocation~~
9 ~~calculated under (g) of this subsection with the facility's nursing~~
10 ~~services component rate in effect on September 30, 1998, less therapy~~
11 ~~costs, plus any exceptional care offsets as reported on the cost~~
12 ~~report, adjusted for economic trends and conditions as provided in RCW~~
13 ~~74.46.431. A facility shall receive the higher of the two rates.~~

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

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

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

33 ~~(v) Effective July 1, 2006, through June 30, 2007, for vital local~~
34 ~~providers, as defined in this chapter, direct care component rate~~
35 ~~allocations shall be determined as follows:~~

36 ~~(A) The department shall calculate:~~

37 ~~(I) The sum of each facility's July 1, 2006, direct care component~~

1 ~~rate allocation calculated under (j) of this subsection and July 1,~~
2 ~~2006, operations component rate calculated under RCW 74.46.521; and~~

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

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

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

13 ~~(j) Except as provided in (i) of this subsection, from July 1,~~
14 ~~2006, forward, and for all future rate setting,)) (f) Determine each~~
15 ~~facility's ((quarterly)) semiannual direct care component rate as~~
16 ~~follows:~~

17 (i) Any facility whose allowable cost per case mix unit is greater
18 than one hundred twelve percent of the peer group median established
19 under ((+f)) (e) of this subsection shall be assigned a cost per case
20 mix unit equal to one hundred twelve percent of the peer group median,
21 and shall have a direct care component rate allocation equal to the
22 facility's assigned cost per case mix unit multiplied by that
23 facility's medicaid average case mix index from the applicable
24 ((quarter)) six-month period specified in RCW 74.46.501((+7)) (6)(c);

25 (ii) Any facility whose allowable cost per case mix unit is less
26 than or equal to one hundred twelve percent of the peer group median
27 established under ((+f)) (e) of this subsection shall have a direct
28 care component rate allocation equal to the facility's allowable cost
29 per case mix unit multiplied by that facility's medicaid average case
30 mix index from the applicable ((quarter)) six-month period specified in
31 RCW 74.46.501((+7)) (6)(c).

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

35 (7) Costs related to payments resulting from increases in direct
36 care component rates, granted under authority of RCW 74.46.508((+1))
37 for a facility's exceptional care residents, shall be offset against
38 the facility's examined, allowable direct care costs, for each report

1 year or partial period such increases are paid. Such reductions in
2 allowable direct care costs shall be for rate setting, settlement, and
3 other purposes deemed appropriate by the department.

4 **Sec. 8.** RCW 74.46.521 and 2007 c 508 s 5 are each amended to read
5 as follows:

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

13 (2) ~~((Except as provided in subsection (4) of this section,~~
14 ~~beginning October 1, 1998,))~~ The department shall determine each
15 medicaid nursing facility's operations component rate allocation using
16 cost report data specified by RCW 74.46.431(7)(a). ~~((Effective July 1,~~
17 ~~2002,))~~ Operations component rates for all facilities except essential
18 community providers and nonessential community providers with sixty or
19 fewer beds shall be based upon a minimum occupancy of ninety-two
20 percent of licensed beds~~((, and no operations component rate shall be~~
21 ~~revised in response to beds banked on or after May 25, 2001, under~~
22 ~~chapter 70.38 RCW))~~.

23 (3) ~~((Except as provided in subsection (4) of this section,))~~ To
24 determine each facility's operations component rate the department
25 shall:

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

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

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

1 the applicable cost report period adjusted if necessary to a minimum
2 occupancy of (~~eighty-five percent of licensed beds before July 1,~~
3 ~~2002, and~~) ninety-two percent (~~(effective July 1, 2002)~~); or

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

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

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

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

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

22 NEW SECTION. Sec. 9. A new section is added to chapter 74.46 RCW
23 to read as follows:

24 The department shall establish, by rule, the procedures,
25 principles, and conditions for a pay for performance supplemental
26 payment structure that provides payment add-ons for high performing
27 facilities. To the extent that funds are appropriated for this
28 purpose, the pay-for-performance structure will include a one percent
29 reduction in payments to facilities with exceptionally high direct care
30 staff turnover, and a method by which the funding that is not paid to
31 these facilities is then used to provide a supplemental payment to
32 facilities with lower direct care staff turnover.

33 NEW SECTION. Sec. 10. RCW 74.46.433 (Variable return component
34 rate allocation) and 2006 c 258 s 3, 2001 1st sp.s. c 8 s 6, & 1999 c
35 353 s 9 are each repealed.

1 NEW SECTION. **Sec. 11.** This act is necessary for the immediate
2 preservation of the public peace, health, or safety, or support of the
3 state government and its existing public institutions, and takes effect
4 immediately.

--- END ---