
SUBSTITUTE SENATE BILL 6872

State of Washington 61st Legislature 2010 Regular Session

By Senate Ways & Means (originally sponsored by Senator Keiser)

READ FIRST TIME 03/09/10.

1 AN ACT Relating to medicaid nursing facility payments; amending RCW
2 74.46.010, 74.46.020, 74.46.431, 74.46.435, 74.46.437, 74.46.439,
3 74.46.475, 74.46.496, 74.46.501, 74.46.506, 74.46.508, 74.46.511,
4 74.46.515, 74.46.521, 74.46.835, and 74.46.800; adding a new section to
5 chapter 74.46 RCW; repealing RCW 74.46.030, 74.46.040, 74.46.050,
6 74.46.060, 74.46.080, 74.46.090, 74.46.100, 74.46.155, 74.46.165,
7 74.46.190, 74.46.200, 74.46.220, 74.46.230, 74.46.240, 74.46.250,
8 74.46.270, 74.46.280, 74.46.290, 74.46.300, 74.46.310, 74.46.320,
9 74.46.330, 74.46.340, 74.46.350, 74.46.360, 74.46.370, 74.46.380,
10 74.46.390, 74.46.410, 74.46.433, 74.46.445, 74.46.533, 74.46.600,
11 74.46.610, 74.46.620, 74.46.625, 74.46.630, 74.46.640, 74.46.650,
12 74.46.660, 74.46.680, 74.46.690, 74.46.700, 74.46.711, 74.46.770,
13 74.46.780, 74.46.790, 74.46.820, 74.46.900, 74.46.901, 74.46.902,
14 74.46.905, and 74.46.906; and providing an effective date.

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

16 **Sec. 1.** RCW 74.46.010 and 1998 c 322 s 1 are each amended to read
17 as follows:

18 (1) This chapter may be known and cited as the "nursing facility
19 medicaid payment system."

1 (2) The purposes of this chapter are to set forth principles to
2 guide the nursing facility medicaid payment system and specify the
3 manner by which legislative appropriations for medicaid nursing
4 facility services are to be allocated as payment rates among nursing
5 facilities(, and to set forth auditing, billing, and other
6 administrative standards associated with payments to nursing home
7 facilities)).

8 (3) The legislature finds that the medicaid nursing facility rates
9 calculated under this chapter provide sufficient reimbursement to
10 efficient and economically operating facilities and bear a reasonable
11 relationship to costs.

12 **Sec. 2.** RCW 74.46.020 and 2007 c 508 s 7 are each amended to read
13 as follows:

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

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

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

27 ~~(3))~~ (2) "Arm's-length transaction" means a transaction
28 resulting from good-faith bargaining between a buyer and seller who are
29 not related organizations and have adverse positions in the market
30 place. Sales or exchanges of nursing home facilities among two or more
31 parties in which all parties subsequently continue to own one or more
32 of the facilities involved in the transactions shall not be considered
33 as arm's-length transactions for purposes of this chapter. Sale of a
34 nursing home facility which is subsequently leased back to the seller
35 within five years of the date of sale shall not be considered as an
36 arm's-length transaction for purposes of this chapter.

1 ~~((4))~~ (3) "Assets" means economic resources of the contractor,
2 recognized and measured in conformity with generally accepted
3 accounting principles.

4 ~~((5))~~ (4) "Audit" or "department audit" means an examination of
5 the records of a nursing facility participating in the medicaid payment
6 system, including but not limited to: The contractor's financial and
7 statistical records, cost reports and all supporting documentation and
8 schedules, receivables, and resident trust funds, to be performed as
9 deemed necessary by the department and according to department rule.

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

12 ~~(7) "Beneficial owner" means:~~

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

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

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

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

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

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

30 ~~(ii) Through the conversion of an ownership interest;~~

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

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

35 ~~except that, any person who acquires an ownership interest or power
36 specified in (c)(i), (ii), or (iii) of this subsection with the purpose
37 or effect of changing or influencing the control of the contractor, or
38 in connection with or as a participant in any transaction having such~~

1 ~~purpose or effect, immediately upon such acquisition shall be deemed to~~
2 ~~be the beneficial owner of the ownership interest which may be acquired~~
3 ~~through the exercise or conversion of such ownership interest or power;~~

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

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

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

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

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

24 ~~(+8))~~ (5) "Capitalization" means the recording of an expenditure as
25 an asset.

26 ~~((+9))~~ (6) "Case mix" means a measure of the intensity of care and
27 services needed by the residents of a nursing facility or a group of
28 residents in the facility.

29 ~~((+10))~~ (7) "Case mix index" means a number representing the
30 average case mix of a nursing facility.

31 ~~((+11))~~ (8) "Case mix weight" means a numeric score that
32 identifies the relative resources used by a particular group of a
33 nursing facility's residents.

34 ~~((+12))~~ (9) "Certificate of capital authorization" means a
35 certification from the department for an allocation from the biennial
36 capital financing authorization for all new or replacement building
37 construction, or for major renovation projects, receiving a certificate

1 of need or a certificate of need exemption under chapter 70.38 RCW
2 after July 1, 2001.

3 ~~((+13+))~~ (10) "Contractor" means a person or entity licensed under
4 chapter 18.51 RCW to operate a medicare and medicaid certified nursing
5 facility, responsible for operational decisions, and contracting with
6 the department to provide services to medicaid recipients residing in
7 the facility.

8 ~~((+14+))~~ (11) "Default case" means no initial assessment has been
9 completed for a resident and transmitted to the department by the
10 cut-off date, or an assessment is otherwise past due for the resident,
11 under state and federal requirements.

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

14 ~~((+16+))~~ (13) "Depreciation" means the systematic distribution of
15 the cost or other basis of tangible assets, less salvage, over the
16 estimated useful life of the assets.

17 ~~((+17+))~~ (14) "Direct care" means nursing care and related care
18 provided to nursing facility residents. Therapy care shall not be
19 considered part of direct care.

20 ~~((+18+))~~ (15) "Direct care supplies" means medical, pharmaceutical,
21 and other supplies required for the direct care of a nursing facility's
22 residents.

23 ~~((+19+))~~ (16) "Entity" means an individual, partnership,
24 corporation, limited liability company, or any other association of
25 individuals capable of entering enforceable contracts.

26 ~~((+20+))~~ (17) "Equity" means the net book value of all tangible and
27 intangible assets less the recorded value of all liabilities, as
28 recognized and measured in conformity with generally accepted
29 accounting principles.

30 ~~((+21+))~~ (18) "Essential community provider" means a facility which
31 is the only nursing facility within a commuting distance radius of at
32 least forty minutes duration, traveling by automobile.

33 ~~((+22+))~~ (19) "Facility" or "nursing facility" means a nursing home
34 licensed in accordance with chapter 18.51 RCW, excepting nursing homes
35 certified as institutions for mental diseases, or that portion of a
36 multiservice facility licensed as a nursing home, or that portion of a
37 hospital licensed in accordance with chapter 70.41 RCW which operates
38 as a nursing home.

1 ~~((+23))~~ (20) "Fair market value" means the replacement cost of an
2 asset less observed physical depreciation on the date for which the
3 market value is being determined.

4 ~~((+24))~~ (21) "Financial statements" means statements prepared and
5 presented in conformity with generally accepted accounting principles
6 including, but not limited to, balance sheet, statement of operations,
7 statement of changes in financial position, and related notes.

8 ~~((+25))~~ (22) "Generally accepted accounting principles" means
9 accounting principles approved by the financial accounting standards
10 board (FASB) or its successor.

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

15 ~~(+27))~~ (23) "Grouper" means a computer software product that groups
16 individual nursing facility residents into case mix classification
17 groups based on specific resident assessment data and computer logic.

18 ~~((+28))~~ (24) "High labor-cost county" means an urban county in
19 which the median allowable facility cost per case mix unit is more than
20 ten percent higher than the median allowable facility cost per case mix
21 unit among all other urban counties, excluding that county.

22 ~~((+29))~~ (25) "Historical cost" means the actual cost incurred in
23 acquiring and preparing an asset for use, including feasibility
24 studies, architect's fees, and engineering studies.

25 ~~((+30))~~ (26) "Home and central office costs" means costs that are
26 incurred in the support and operation of a home and central office.
27 Home and central office costs include centralized services that are
28 performed in support of a nursing facility. The department may exclude
29 from this definition costs that are nonduplicative, documented,
30 ordinary, necessary, and related to the provision of care services to
31 authorized patients.

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

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

37 ~~(+33))~~ (27) "Lease agreement" means a contract between two parties
38 for the possession and use of real or personal property or assets for

1 a specified period of time in exchange for specified periodic payments.
2 Elimination (due to any cause other than death or divorce) or addition
3 of any party to the contract, expiration, or modification of any lease
4 term in effect on January 1, 1980, or termination of the lease by
5 either party by any means shall constitute a termination of the lease
6 agreement. An extension or renewal of a lease agreement, whether or
7 not pursuant to a renewal provision in the lease agreement, shall be
8 considered a new lease agreement. A strictly formal change in the
9 lease agreement which modifies the method, frequency, or manner in
10 which the lease payments are made, but does not increase the total
11 lease payment obligation of the lessee, shall not be considered
12 modification of a lease term.

13 ~~((+34+))~~ (28) "Medical care program" or "medicaid program" means
14 medical assistance, including nursing care, provided under RCW
15 74.09.500 or authorized state medical care services.

16 ~~((+35+))~~ (29) "Medical care recipient," "medicaid recipient," or
17 "recipient" means an individual determined eligible by the department
18 for the services provided under chapter 74.09 RCW.

19 ~~((+36+))~~ (30) "Minimum data set" means the overall data component
20 of the resident assessment instrument, indicating the strengths, needs,
21 and preferences of an individual nursing facility resident.

22 ~~((+37+))~~ (31) "Net book value" means the historical cost of an
23 asset less accumulated depreciation.

24 ~~((+38+))~~ (32) "Net invested funds" means the net book value of
25 tangible fixed assets employed by a contractor to provide services
26 under the medical care program, including land, buildings, and
27 equipment as recognized and measured in conformity with generally
28 accepted accounting principles.

29 ~~((+39+))~~ (33) "Nonurban county" means a county which is not located
30 in a metropolitan statistical area as determined and defined by the
31 United States office of management and budget or other appropriate
32 agency or office of the federal government.

33 ~~((+40+))~~ ~~"Operating lease" means a lease under which rental or lease~~
34 ~~expenses are included in current expenses in accordance with generally~~
35 ~~accepted accounting principles.~~

36 ~~(+41+))~~ (34) "Owner" means a sole proprietor, general or limited
37 partners, members of a limited liability company, and beneficial

1 interest holders of five percent or more of a corporation's outstanding
2 stock.

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

6 ~~(43))~~ (35) "Patient day" or "resident day" means a calendar day of
7 care provided to a nursing facility resident, regardless of payment
8 source, which will include the day of admission and exclude the day of
9 discharge; except that, when admission and discharge occur on the same
10 day, one day of care shall be deemed to exist. A "medicaid day" or
11 "recipient day" means a calendar day of care provided to a medicaid
12 recipient determined eligible by the department for services provided
13 under chapter 74.09 RCW, subject to the same conditions regarding
14 admission and discharge applicable to a patient day or resident day of
15 care.

16 ~~((44) "Professionally designated real estate appraiser" means an
17 individual who is regularly engaged in the business of providing real
18 estate valuation services for a fee, and who is deemed qualified by a
19 nationally recognized real estate appraisal educational organization on
20 the basis of extensive practical appraisal experience, including the
21 writing of real estate valuation reports as well as the passing of
22 written examinations on valuation practice and theory, and who by
23 virtue of membership in such organization is required to subscribe and
24 adhere to certain standards of professional practice as such
25 organization prescribes.~~

26 ~~(45))~~ (36) "Qualified therapist" means:

27 (a) A mental health professional as defined by chapter 71.05 RCW;

28 (b) A mental retardation professional who is a therapist approved
29 by the department who has had specialized training or one year's
30 experience in treating or working with the mentally retarded or
31 developmentally disabled;

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

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

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

1 (f) A respiratory care practitioner certified under chapter 18.89
2 RCW.

3 ~~((46))~~ (37) "Rate" or "rate allocation" means the medicaid per-
4 patient-day payment amount for medicaid patients calculated in
5 accordance with the allocation methodology set forth in part E of this
6 chapter.

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

10 ~~(48))~~ (38) "Rebased rate" or "cost-rebased rate" means a facility-
11 specific component rate assigned to a nursing facility for a particular
12 rate period established on desk-reviewed, adjusted costs reported for
13 that facility covering at least six months of a prior calendar year
14 designated as a year to be used for cost-rebasing payment rate
15 allocations under the provisions of this chapter.

16 ~~((49))~~ (39) "Records" means those data supporting all financial
17 statements and cost reports including, but not limited to, all general
18 and subsidiary ledgers, books of original entry, and transaction
19 documentation, however such data are maintained.

20 ~~((50) "Related organization" means an entity which is under common
21 ownership and/or control with, or has control of, or is controlled by,
22 the contractor.~~

23 ~~(a) "Common ownership" exists when an entity is the beneficial
24 owner of five percent or more ownership interest in the contractor and
25 any other entity.~~

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

30 ~~(51) "Related care" means only those services that are directly
31 related to providing direct care to nursing facility residents. These
32 services include, but are not limited to, nursing direction and
33 supervision, medical direction, medical records, pharmacy services,
34 activities, and social services.~~

35 ~~(52))~~ (40) "Resident assessment instrument," including federally
36 approved modifications for use in this state, means a federally
37 mandated, comprehensive nursing facility resident care planning and

1 assessment tool, consisting of the minimum data set and resident
2 assessment protocols.

3 ~~((+53+))~~ (41) "Resident assessment protocols" means those
4 components of the resident assessment instrument that use the minimum
5 data set to trigger or flag a resident's potential problems and risk
6 areas.

7 ~~((+54+))~~ (42) "Resource utilization groups" means a case mix
8 classification system that identifies relative resources needed to care
9 for an individual nursing facility resident.

10 ~~((+55) "Restricted fund" means those funds the principal and/or
11 income of which is limited by agreement with or direction of the donor
12 to a specific purpose.~~

13 ~~(+56+))~~ (43) "Secretary" means the secretary of the department of
14 social and health services.

15 ~~((+57+))~~ (44) "Support services" means food, food preparation,
16 dietary, housekeeping, and laundry services provided to nursing
17 facility residents.

18 ~~((+58+))~~ (45) "Therapy care" means those services required by a
19 nursing facility resident's comprehensive assessment and plan of care,
20 that are provided by qualified therapists, or support personnel under
21 their supervision, including related costs as designated by the
22 department.

23 ~~((+59+))~~ (46) "Title XIX" or "medicaid" means the 1965 amendments
24 to the social security act, P.L. 89-07, as amended and the medicaid
25 program administered by the department.

26 ~~((+60+))~~ (47) "Urban county" means a county which is located in a
27 metropolitan statistical area as determined and defined by the United
28 States office of management and budget or other appropriate agency or
29 office of the federal government.

30 ~~((+61) "Vital local provider" means a facility that meets the
31 following qualifications:~~

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

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

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

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

5 **Sec. 3.** RCW 74.46.431 and 2009 c 570 s 1 are each amended to read
6 as follows:

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

14 (2) Component rate allocations in therapy care, support services,
15 ~~((variable return,))~~ operations, property, and financing allowance for
16 ~~((essential community))~~ all providers as defined in this chapter shall
17 be based upon a minimum facility occupancy of ~~((eighty-five))~~
18 ninety-five percent of licensed beds, regardless of how many beds are
19 set up or in use. ~~((For all facilities other than essential community~~
20 ~~providers, effective July 1, 2001, component rate allocations in direct~~
21 ~~care, therapy care, support services, and variable return shall be~~
22 ~~based upon a minimum facility occupancy of eighty five percent of~~
23 ~~licensed beds. For all facilities other than essential community~~
24 ~~providers, effective July 1, 2002, the component rate allocations in~~
25 ~~operations, property, and financing allowance shall be based upon a~~
26 ~~minimum facility occupancy of ninety percent of licensed beds,~~
27 ~~regardless of how many beds are set up or in use.))~~ For all
28 facilities, ~~((effective July 1, 2006,))~~ the component rate allocation
29 in direct care shall be based upon actual facility occupancy. The
30 median cost limits used to set component rate allocations shall be
31 based on the applicable minimum occupancy percentage. In determining
32 each facility's therapy care component rate allocation under RCW
33 74.46.511, the department shall apply the applicable minimum facility
34 occupancy adjustment before creating the array of facilities' adjusted
35 therapy costs per adjusted resident day. In determining each
36 facility's support services component rate allocation under RCW
37 74.46.515(3), the department shall apply the applicable minimum

1 facility occupancy adjustment before creating the array of facilities'
2 adjusted support services costs per adjusted resident day. In
3 determining each facility's operations component rate allocation under
4 RCW 74.46.521(3), the department shall apply the minimum facility
5 occupancy adjustment before creating the array of facilities' adjusted
6 general operations costs per adjusted resident day.

7 (3) Information and data sources used in determining medicaid
8 payment rate allocations, including formulas, procedures, cost report
9 periods, resident assessment instrument formats, resident assessment
10 methodologies, and resident classification and case mix weighting
11 methodologies, may be substituted or altered from time to time as
12 determined by the department.

13 (4)(a) Direct care component rate allocations shall be established
14 using adjusted cost report data covering at least six months.
15 (~~Adjusted cost report data from 1996 will be used for October 1, 1998,~~
16 ~~through June 30, 2001, direct care component rate allocations; adjusted~~
17 ~~cost report data from 1999 will be used for July 1, 2001, through June~~
18 ~~30, 2006, direct care component rate allocations. Adjusted cost report~~
19 ~~data from 2003 will be used for July 1, 2006, through June 30, 2007,~~
20 ~~direct care component rate allocations. Adjusted cost report data from~~
21 ~~2005 will be used for July 1, 2007, through June 30, 2009, direct care~~
22 ~~component rate allocations.)) Effective July 1, 2009, the direct care
23 component rate allocation shall be rebased biennially, and thereafter
24 for each odd-numbered year beginning July 1st, using the adjusted cost
25 report data for the calendar year two years immediately preceding the
26 rate rebase period, so that adjusted cost report data for calendar year
27 2007 is used for July 1, 2009, through June 30, 2011, and so forth.~~

28 (b) (~~Direct care component rate allocations based on 1996 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 (c) ~~Direct care component rate allocations based on 1999 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, 1998, rate, as provided in RCW~~
5 ~~74.46.506(5)(i).~~

6 ~~(d) Direct care component rate allocations based on 2003 cost~~
7 ~~report data shall be adjusted annually for economic trends and~~
8 ~~conditions by a factor or factors defined in the biennial~~
9 ~~appropriations act. A different economic trends and conditions~~
10 ~~adjustment factor or factors may be defined in the biennial~~
11 ~~appropriations act for facilities whose direct care component rate is~~
12 ~~set equal to their adjusted June 30, 2006, rate, as provided in RCW~~
13 ~~74.46.506(5)(i).~~

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

28 (5)(a) Therapy care component rate allocations shall be established
29 using adjusted cost report data covering at least six months.
30 ~~((Adjusted cost report data from 1996 will be used for October 1, 1998,~~
31 ~~through June 30, 2001, therapy care component rate allocations;~~
32 ~~adjusted cost report data from 1999 will be used for July 1, 2001,~~
33 ~~through June 30, 2005, therapy care component rate allocations.~~
34 ~~Adjusted cost report data from 1999 will continue to be used for July~~
35 ~~1, 2005, through June 30, 2007, therapy care component rate~~
36 ~~allocations. Adjusted cost report data from 2005 will be used for July~~
37 ~~1, 2007, through June 30, 2009, therapy care component rate~~
38 ~~allocations.))~~ Effective July 1, 2009, and thereafter for each

1 odd-numbered year beginning July 1st, the therapy care component rate
2 allocation shall be cost rebased biennially, using the adjusted cost
3 report data for the calendar year two years immediately preceding the
4 rate rebase period, so that adjusted cost report data for calendar year
5 2007 is used for July 1, 2009, through June 30, 2011, and so forth.

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

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

37 (b) Support services component rate allocations established in
38 accordance with this chapter shall be adjusted annually for economic

1 trends and conditions by a factor or factors defined in the biennial
2 appropriations act. The economic trends and conditions factor or
3 factors defined in the biennial appropriations act shall not be
4 compounded with the economic trends and conditions factor or factors
5 defined in any other biennial appropriations acts before applying it to
6 the support services component rate allocation established in
7 accordance with this chapter. When no economic trends and conditions
8 factor or factors for either fiscal year are defined in a biennial
9 appropriations act, no economic trends and conditions factor or factors
10 defined in any earlier biennial appropriations act shall be applied
11 solely or compounded to the support services component rate allocation
12 established in accordance with this chapter.

13 (7)(a) Operations component rate allocations shall be established
14 using adjusted cost report data covering at least six months.
15 (~~Adjusted cost report data from 1996 shall be used for October 1,~~
16 ~~1998, through June 30, 2001, operations component rate allocations;~~
17 ~~adjusted cost report data from 1999 shall be used for July 1, 2001,~~
18 ~~through June 30, 2006, operations component rate allocations. Adjusted~~
19 ~~cost report data from 2003 will be used for July 1, 2006, through June~~
20 ~~30, 2007, operations component rate allocations. Adjusted cost report~~
21 ~~data from 2005 will be used for July 1, 2007, through June 30, 2009,~~
22 ~~operations component rate allocations.)) Effective July 1, 2009, and
23 thereafter for each odd-numbered year beginning July 1st, the
24 operations component rate allocation shall be cost rebased biennially,
25 using the adjusted cost report data for the calendar year two years
26 immediately preceding the rate rebase period, so that adjusted cost
27 report data for calendar year 2007 is used for July 1, 2009, through
28 June 30, 2011, and so forth.~~

29 (b) Operations component rate allocations established in accordance
30 with this chapter shall be adjusted annually for economic trends and
31 conditions by a factor or factors defined in the biennial
32 appropriations act. The economic trends and conditions factor or
33 factors defined in the biennial appropriations act shall not be
34 compounded with the economic trends and conditions factor or factors
35 defined in any other biennial appropriations acts before applying it to
36 the operations component rate allocation established in accordance with
37 this chapter. When no economic trends and conditions factor or factors
38 for either fiscal year are defined in a biennial appropriations act, no

1 economic trends and conditions factor or factors defined in any earlier
2 biennial appropriations act shall be applied solely or compounded to
3 the operations component rate allocation established in accordance with
4 this chapter. (~~A different economic trends and conditions adjustment~~
5 ~~factor or factors may be defined in the biennial appropriations act for~~
6 ~~facilities whose operations component rate is set equal to their~~
7 ~~adjusted June 30, 2006, rate, as provided in RCW 74.46.521(4).~~

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

15 ~~(9))~~ (8) Total payment rates under the nursing facility medicaid
16 payment system shall not exceed facility rates charged to the general
17 public for comparable services.

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

21 ~~(11))~~ (9) The department shall establish in rule procedures,
22 principles, and conditions for determining component rate allocations
23 for facilities in circumstances not directly addressed by this chapter,
24 including but not limited to: (~~The need to prorate~~) Inflation
25 adjustments for partial-period cost report data, newly constructed
26 facilities, existing facilities entering the medicaid program for the
27 first time or after a period of absence from the program, existing
28 facilities with expanded new bed capacity, existing medicaid facilities
29 following a change of ownership of the nursing facility business,
30 facilities banking beds or converting beds back into service,
31 facilities temporarily reducing the number of set-up beds during a
32 remodel, facilities having less than six months of either resident
33 assessment, cost report data, or both, under the current contractor
34 prior to rate setting, and other circumstances.

35 ~~((12))~~ (10) The department shall establish in rule procedures,
36 principles, and conditions, including necessary threshold costs, for
37 adjusting rates to reflect capital improvements or new requirements

1 imposed by the department or the federal government. Any such rate
2 adjustments are subject to the provisions of RCW 74.46.421.

3 ~~((+13))~~ (11) Effective July 1, 2001, medicaid rates shall continue
4 to be revised downward in all components, in accordance with department
5 rules, for facilities converting banked beds to active service under
6 chapter 70.38 RCW, by using the facility's increased licensed bed
7 capacity to recalculate minimum occupancy for rate setting. However,
8 for facilities other than essential community providers which bank beds
9 under chapter 70.38 RCW, after May 25, 2001, medicaid rates shall be
10 revised upward, in accordance with department rules, in direct care,
11 therapy care, and support services(~~(, and variable return)~~) components
12 only, by using the facility's decreased licensed bed capacity to
13 recalculate minimum occupancy for rate setting, but no upward revision
14 shall be made to operations, property, or financing allowance component
15 rates. Effective July 1, 2006, the direct care component rate
16 allocation shall be (~~adjusted, without using the minimum occupancy~~
17 ~~assumption, for facilities that convert banked beds to active service,~~
18 ~~under chapter 70.38 RCW, beginning on July 1, 2006. Effective July 1,~~
19 ~~2007, component rate allocations for direct care shall be~~) based on
20 actual patient days regardless of whether a facility has converted
21 banked beds to active service.

22 ~~((+14))~~ (12) Facilities obtaining a certificate of need or a
23 certificate of need exemption under chapter 70.38 RCW after June 30,
24 2001, must have a certificate of capital authorization in order for (a)
25 the depreciation resulting from the capitalized addition to be included
26 in calculation of the facility's property component rate allocation;
27 and (b) the net invested funds associated with the capitalized addition
28 to be included in calculation of the facility's financing allowance
29 rate allocation.

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

32 (1) (~~Effective July 1, 2001,~~) The property component rate
33 allocation for each facility shall be determined by dividing the sum of
34 the reported allowable prior period actual depreciation, subject to
35 (~~RCW 74.46.310 through 74.46.380~~) department rule, adjusted for any
36 capitalized additions or replacements approved by the department, and
37 the retained savings from such cost center, by the greater of a

1 facility's total resident days for the facility in the prior period or
2 resident days as calculated on (~~eighty-five~~) ninety-five percent
3 facility occupancy. (~~Effective July 1, 2002, the property component~~
4 ~~rate allocation for all facilities, except essential community~~
5 ~~providers, shall be set by using the greater of a facility's total~~
6 ~~resident days from the most recent cost report period or resident days~~
7 ~~calculated at ninety percent facility occupancy.~~) If a capitalized
8 addition or retirement of an asset will result in a different licensed
9 bed capacity during the ensuing period, the prior period total resident
10 days used in computing the property component rate shall be adjusted to
11 anticipated resident day level.

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

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

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

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

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

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

6 (2) (~~Effective July 1, 2001,~~) The financing allowance shall be
7 determined by multiplying the net invested funds of each facility by
8 .10, and dividing by the greater of a nursing facility's total resident
9 days from the most recent cost report period or resident days
10 calculated on (~~eighty-five~~) ninety-five percent facility occupancy.
11 (~~Effective July 1, 2002, the financing allowance component rate~~
12 ~~allocation for all facilities, other than essential community~~
13 ~~providers, shall be set by using the greater of a facility's total~~
14 ~~resident days from the most recent cost report period or resident days~~
15 ~~calculated at ninety percent facility occupancy.~~) However, assets
16 acquired on or after May 17, 1999, shall be grouped in a separate
17 financing allowance calculation that shall be multiplied by (~~.085~~)
18 0.04. The financing allowance factor of (~~.085~~) 0.04 shall not be
19 applied to the net invested funds pertaining to new construction or
20 major renovations receiving certificate of need approval or an
21 exemption from certificate of need requirements under chapter 70.38
22 RCW, or to working drawings that have been submitted to the department
23 of health for construction review approval, prior to May 17, 1999. If
24 a capitalized addition, renovation, replacement, or retirement of an
25 asset will result in a different licensed bed capacity during the
26 ensuing period, the prior period total resident days used in computing
27 the financing allowance shall be adjusted to the greater of the
28 anticipated resident day level or (~~eighty-five~~) ninety-five percent
29 of the new licensed bed capacity. Effective July 1, 2002, for all
30 facilities(~~, other than essential community providers,~~) the total
31 resident days used to compute the financing allowance after a
32 capitalized addition, renovation, replacement, or retirement of an
33 asset shall be set by using the greater of a facility's total resident
34 days from the most recent cost report period or resident days
35 calculated at ninety-five percent facility occupancy.

36 (3) In computing the portion of net invested funds representing the
37 net book value of tangible fixed assets, the same assets, depreciation
38 bases, lives, and methods referred to in (~~RCW 74.46.330, 74.46.350,~~

1 ~~74.46.360, 74.46.370, and 74.46.380~~) rule, including owned and leased
2 assets, shall be utilized, except that the capitalized cost of land
3 upon which the facility is located and such other contiguous land which
4 is reasonable and necessary for use in the regular course of providing
5 resident care shall also be included. Subject to provisions and
6 limitations contained in this chapter, for land purchased by owners or
7 lessors before July 18, 1984, capitalized cost of land shall be the
8 buyer's capitalized cost. For all partial or whole rate periods after
9 July 17, 1984, if the land is purchased after July 17, 1984,
10 capitalized cost shall be that of the owner of record on July 17, 1984,
11 or buyer's capitalized cost, whichever is lower. In the case of leased
12 facilities where the net invested funds are unknown or the contractor
13 is unable to provide necessary information to determine net invested
14 funds, the secretary shall have the authority to determine an amount
15 for net invested funds based on an appraisal conducted according to
16 (~~RCW 74.46.360(1)~~) department rule.

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

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

34 **Sec. 6.** RCW 74.46.439 and 1999 c 353 s 12 are each amended to read
35 as follows:

36 (1) In the case of a facility that was leased by the contractor as
37 of January 1, 1980, in an arm's-length agreement, which continues to be

1 leased under the same lease agreement, ~~((and for which the annualized~~
2 ~~lease payment, plus any interest and depreciation expenses associated~~
3 ~~with contractor-owned assets, for the period covered by the prospective~~
4 ~~rates, divided by the contractor's total resident days, minus the~~
5 ~~property component rate allocation, is more than the sum of the~~
6 ~~financing allowance and the variable return rate determined according~~
7 ~~to this chapter, the following shall apply:~~

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

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

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

28 ~~(2) In the case of a facility that was leased by the contractor as~~
29 ~~of January 1, 1980, in an arm's length agreement, if the lease is~~
30 ~~renewed or extended under a provision of the lease, the treatment~~
31 ~~provided in subsection (1) of this section shall be applied, except~~
32 ~~that in the case of renewals or extensions made subsequent to April 1,~~
33 ~~1985, reimbursement for the annualized lease payment shall be no~~
34 ~~greater than the reimbursement for the annualized lease payment for the~~
35 ~~last year prior to the renewal or extension of the lease.~~

36 ~~(3)) the financing allowance rate will be the lesser of the rate~~
37 ~~existing on June 30, 2010, or the rate calculated under RCW 74.46.437.~~

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

4 **Sec. 7.** RCW 74.46.475 and 1998 c 322 s 21 are each amended to read
5 as follows:

6 (~~(1)~~) The department shall analyze the submitted cost report or
7 a portion thereof of each contractor for each report period to
8 determine if the information is correct, complete, reported in
9 conformance with department instructions and generally accepted
10 accounting principles, the requirements of this chapter, and such rules
11 as the department may adopt. If the analysis finds that the cost
12 report is incorrect or incomplete, the department may make adjustments
13 to the reported information for purposes of establishing payment rate
14 allocations. A schedule of such adjustments shall be provided to
15 contractors and shall include an explanation for the adjustment and the
16 dollar amount of the adjustment. Adjustments shall be subject to
17 review and appeal as provided in this chapter.

18 (~~(2) The department shall accumulate data from properly completed~~
19 ~~cost reports, in addition to assessment data on each facility's~~
20 ~~resident population characteristics, for use in:~~

21 ~~(a) Exception profiling; and~~

22 ~~(b) Establishing rates.~~

23 ~~(3) The department may further utilize such accumulated data for~~
24 ~~analytical, statistical, or informational purposes as necessary.))~~

25 **Sec. 8.** RCW 74.46.496 and 2006 c 258 s 4 are each amended to read
26 as follows:

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

33 (2) The case mix weights shall be based on the average minutes per
34 registered nurse, licensed practical nurse, and certified nurse aide,
35 for each case mix group, and using the (~~health care financing~~
36 ~~administration of the~~) United States department of health and human

1 services 1995 nursing facility staff time measurement study stemming
2 from its multistate nursing home case mix and quality demonstration
3 project. Those minutes shall be weighted by statewide ratios of
4 registered nurse to certified nurse aide, and licensed practical nurse
5 to certified nurse aide, wages, including salaries and benefits, which
6 shall be based on 1995 cost report data for this state.

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

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

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

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

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

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

1 **Sec. 9.** RCW 74.46.501 and 2006 c 258 s 5 are each amended to read
2 as follows:

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

8 (2)(a) In calculating a facility's two average case mix indexes for
9 each quarter, the department shall include all residents or medicaid
10 residents, as applicable, who were physically in the facility during
11 the quarter in question based on the resident assessment instrument
12 completed by the facility and the requirements and limitations for the
13 instrument's completion and transmission (January 1st through March
14 31st, April 1st through June 30th, July 1st through September 30th, or
15 October 1st through December 31st).

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

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

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

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

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

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

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

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

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

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

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

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

28 (6) ~~((A threshold of ninety percent, as described and calculated in~~
29 ~~this subsection, shall be used to determine the case mix index each~~
30 ~~quarter. The threshold shall also be used to determine which~~
31 ~~facilities' costs per case mix unit are included in determining the~~
32 ~~ceiling, floor, and price. For direct care component rate allocations~~
33 ~~established on and after July 1, 2006, the threshold of ninety percent~~
34 ~~shall be used to determine the case mix index each quarter and to~~
35 ~~determine which facilities' costs per case mix unit are included in~~
36 ~~determining the ceiling and price. If the facility does not meet the~~
37 ~~ninety percent threshold, the department may use an alternate case mix~~
38 ~~index to determine the facility average and medicaid average case mix~~

1 indexes for the quarter. The threshold is a count of unique minimum
2 data set assessments, and it shall include resident assessment
3 instrument tracking forms for residents discharged prior to completing
4 an initial assessment. The threshold is calculated by dividing a
5 facility's count of residents being assessed by the average census for
6 the facility. A daily census shall be reported by each nursing
7 facility as it transmits assessment data to the department. The
8 department shall compute a quarterly average census based on the daily
9 census. If no census has been reported by a facility during a
10 specified quarter, then the department shall use the facility's
11 licensed beds as the denominator in computing the threshold.

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

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

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

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

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

35 (c) The medicaid average case mix index used to update or
36 recalibrate a nursing facility's direct care component rate quarterly
37 shall be from the calendar quarter commencing six months prior to the
38 effective date of the quarterly rate. For example, October 1, 1998,

1 through December 31, 1998, direct care component rates shall utilize
2 case mix averages from the April 1, 1998, through June 30, 1998,
3 calendar quarter, and so forth.

4 **Sec. 10.** 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 for each nursing facility serving medicaid
15 residents a facility-specific per-resident day direct care component
16 rate allocation, to be effective on the first day of each calendar
17 quarter. In determining direct care component rates the department
18 shall utilize, as specified in this section, minimum data set resident
19 assessment data for each resident of the facility, as transmitted to,
20 and if necessary corrected by, the department in the resident
21 assessment instrument format approved by federal authorities for use in
22 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 as described in RCW
2 74.46.496 and 74.46.501, consistent with the 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 direct care component 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)) (e) of this subsection shall be assigned a cost per case
19 mix unit equal to one hundred twelve percent of the peer group median,
20 and shall have a direct care component rate allocation equal to the
21 facility's assigned cost per case mix unit multiplied by that
22 facility's medicaid average case mix index from the applicable quarter
23 specified in RCW 74.46.501((+7)) (6)(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)) (e) of this subsection shall have a direct
27 care component rate allocation equal to the facility's allowable cost
28 per case mix unit multiplied by that facility's medicaid average case
29 mix index from the applicable quarter specified in RCW 74.46.501((+7))
30 (6)(c).
31 (6) The direct care component rate allocations calculated in
32 accordance with this section shall be adjusted to the extent necessary
33 to comply with RCW 74.46.421.
34 (7) Costs related to payments resulting from increases in direct
35 care component rates, granted under authority of RCW 74.46.508((+1))
36 for a facility's exceptional care residents, shall be offset against
37 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. 11.** RCW 74.46.508 and 2003 1st sp.s. c 6 s 1 are each amended
5 to read as follows:

6 ~~((1))~~ The department is authorized to increase the direct care
7 component rate allocation calculated under RCW 74.46.506(5) for
8 residents who have unmet exceptional care needs as determined by the
9 department in rule. The department may, by rule, establish criteria,
10 patient categories, and methods of exceptional care payment.

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

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

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

21 **Sec. 12.** RCW 74.46.511 and 2008 c 263 s 3 are each amended to read
22 as follows:

23 (1) The therapy care component rate allocation corresponds to the
24 provision of medicaid one-on-one therapy provided by a qualified
25 therapist as defined in this chapter, including therapy supplies and
26 therapy consultation, for one day for one medicaid resident of a
27 nursing facility. ~~((The therapy care component rate allocation for
28 October 1, 1998, through June 30, 2001, shall be based on adjusted
29 therapy costs and days from calendar year 1996. The therapy component
30 rate allocation for July 1, 2001, through June 30, 2007, shall be based
31 on adjusted therapy costs and days from calendar year 1999. Effective
32 July 1, 2007,))~~ The therapy care component rate allocation shall be
33 based on adjusted therapy costs and days as described in RCW
34 74.46.431(5). The therapy care component rate shall be adjusted for
35 economic trends and conditions as specified in RCW 74.46.431(5), and
36 shall be determined in accordance with this section. In determining

1 each facility's therapy care component rate allocation, the department
2 shall apply the applicable minimum facility occupancy adjustment before
3 creating the array of facilities' adjusted therapy care costs per
4 adjusted resident day.

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

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

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

14 (c) Therapy consulting expenses for all residents.

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

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

21 (a) Those facilities located within urban counties; and

22 (b) Those located within nonurban counties.

23 The department shall array the facilities in each peer group from
24 highest to lowest based on their total cost per unit of therapy for
25 each therapy type. (~~The department shall determine the median total
26 cost per unit of therapy for each therapy type and add ten percent of
27 median total cost per unit of therapy.~~) The cost per unit of therapy
28 for each therapy type at a nursing facility shall be the lesser of its
29 cost per unit of therapy for each therapy type or the median total cost
30 per unit (~~plus ten percent~~) for each therapy type for its peer group.

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

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

37 (b) The medicaid allowable one-on-one therapy expense shall be

1 calculated taking the allowable total therapy cost for each therapy
2 type times the medicaid percent of total therapy charges for each
3 therapy type;

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

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

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

19 (f) The total allowable therapy expense will be divided by the
20 greater of adjusted total patient days from the cost report on which
21 the therapy expenses were reported, or patient days at ((~~eighty-five~~)
22 ninety-five percent occupancy of licensed beds. The outcome shall be
23 the nursing facility's therapy care component rate allocation.

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

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

31 **Sec. 13.** RCW 74.46.515 and 2008 c 263 s 4 are each amended to read
32 as follows:

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

36 (2) ((~~Beginning October 1, 1998,~~)) The department shall determine

1 each medicaid nursing facility's support services component rate
2 allocation using cost report data specified by RCW 74.46.431(6).

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

5 (a) Array facilities' adjusted support services costs per adjusted
6 resident day, as determined by dividing each facility's total allowable
7 support services costs by its adjusted resident days for the same
8 report period, increased if necessary to a minimum occupancy provided
9 by RCW 74.46.431(2), for each facility from facilities' cost reports
10 from the applicable report year, for facilities located within urban
11 counties, and for those located within nonurban counties and determine
12 the median adjusted cost for each peer group;

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

18 (c) Adjust each facility's support services component rate for
19 economic trends and conditions as provided in RCW 74.46.431(6).

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

23 **Sec. 14.** RCW 74.46.521 and 2007 c 508 s 5 are each amended to read
24 as follows:

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

32 (~~((Except as provided in subsection (4) of this section,~~
33 ~~beginning October 1, 1998,))~~) The department shall determine each
34 medicaid nursing facility's operations component rate allocation using
35 cost report data specified by RCW 74.46.431(7)(a). (~~(Effective July 1,~~
36 ~~2002,))~~) Operations component rates for all facilities (~~((except~~
37 ~~essential community providers))~~) shall be based upon a minimum occupancy

1 of ninety-five percent of licensed beds, and no operations component
2 rate shall be revised in response to beds banked on or after May 25,
3 2001, under chapter 70.38 RCW.

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

7 (a) Array facilities' adjusted general operations costs per
8 adjusted resident day, as determined by dividing each facility's total
9 allowable operations cost by its adjusted resident days for the same
10 report period, increased if necessary to a minimum occupancy of
11 ninety-five percent; that is, the greater of actual or imputed
12 occupancy at ninety-five percent of licensed beds, for each facility
13 from facilities' cost reports from the applicable report year, for
14 facilities located within urban counties and for those located within
15 nonurban counties and determine the median adjusted cost for each peer
16 group;

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

18 (i) The facility's per resident day adjusted operations costs from
19 the applicable cost report period adjusted if necessary to a minimum
20 occupancy of (~~eighty-five percent of licensed beds before July 1,~~
21 ~~2002, and~~) ninety-five percent (~~(effective July 1, 2002)~~); or

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

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

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

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

37 ~~(5))~~ The operations component rate allocations calculated in

1 accordance with this section shall be adjusted to the extent necessary
2 to comply with RCW 74.46.421.

3 **Sec. 15.** RCW 74.46.835 and 1998 c 322 s 46 are each amended to
4 read as follows:

5 (1) Payment for direct care at the pilot nursing facility in King
6 county designed to meet the service needs of residents living with
7 AIDS, as defined in RCW 70.24.017, and as specifically authorized for
8 this purpose under chapter 9, Laws of 1989 1st ex. sess., shall be
9 exempt from case mix methods of rate determination set forth in this
10 chapter and shall be exempt from the direct care metropolitan
11 statistical area peer group cost limitation set forth in this chapter.

12 (2) Direct care component rates at the AIDS pilot facility shall be
13 based on direct care reported costs at the pilot facility, utilizing
14 the same (~~three-year~~) rate-setting cycle prescribed for other
15 nursing facilities, and as supported by a staffing benchmark based upon
16 a department-approved acuity measurement system.

17 (3) The provisions of RCW 74.46.421 and all other rate-setting
18 principles, cost lids, and limits, including settlement as provided in
19 RCW 74.46.165 shall apply to the AIDS pilot facility.

20 (4) This section applies only to the AIDS pilot nursing facility.

21 **Sec. 16.** RCW 74.46.800 and 1998 c 322 s 42 are each amended to
22 read as follows:

23 (1) The department shall have authority to adopt, amend, and
24 rescind such administrative rules and definitions as it deems necessary
25 to carry out the policies and purposes of this chapter and to resolve
26 issues and develop procedures (~~that it deems necessary~~) to implement,
27 update, and improve (~~the case mix elements of~~) the nursing facility
28 medicaid payment system.

29 (2) Nothing in this chapter shall be construed to require the
30 department to adopt or employ any calculations, steps, tests,
31 methodologies, alternate methodologies, indexes, formulas, mathematical
32 or statistical models, concepts, or procedures for medicaid rate
33 setting or payment that are not expressly called for in this chapter.

34 NEW SECTION. **Sec. 17.** A new section is added to chapter 74.46 RCW
35 to read as follows:

1 The department shall establish, by rule, the procedures,
2 principles, and conditions for the nursing facility medicaid payment
3 system addressed by the following principles:

4 (1) The department must receive complete, annual reporting of all
5 costs and the financial condition of each contractor, prepared and
6 presented in a standardized manner. The department shall establish, by
7 rule, due dates, requirements for cost report completion, actions
8 required for improperly completed or late cost reports, fines for any
9 statutory or regulatory noncompliance, retention requirements, and
10 public disclosure requirements.

11 (2) The department shall examine all cost reports to determine
12 whether the information is correct, complete, and reported in
13 compliance with this chapter, department rules and instructions, and
14 generally accepted accounting principles.

15 (3) Each contractor must establish and maintain, as a service to
16 the resident, a bookkeeping system incorporated into the business
17 records for all resident funds entrusted to the contractor and received
18 by the contractor for the resident. The department shall adopt rules
19 to ensure that resident personal funds handled by the contractor are
20 maintained by each contractor in a manner that is, at a minimum,
21 consistent with federal requirements.

22 (4) The department shall have the authority to audit resident trust
23 funds and receivables, at its discretion.

24 (5) Contractors shall provide the department access to the nursing
25 facility, all financial and statistical records, and all working papers
26 that are in support of the cost report, receivables, and resident trust
27 funds.

28 (6) The department shall establish a settlement process in order to
29 reconcile medicaid resident days to billed days and medicaid payments
30 for the preceding calendar year. The settlement process shall ensure
31 that any savings in the direct care or therapy care component rates be
32 shifted only between direct care and therapy care component rates, and
33 shall not be shifted into any other rate components.

34 (7) The department shall define and identify allowable and
35 unallowable costs.

36 (8) A contractor shall bill the department for care provided to
37 medicaid recipients, and the department shall pay a contractor for

1 service rendered under the facility contract and appropriately billed.
2 Billing and payment procedures shall be specified by rule.

3 (9) The department shall establish the conditions for participation
4 in the nursing facility medicaid payment system.

5 (10) The department shall establish procedures and a rate setting
6 methodology for a change of ownership.

7 (11) The department shall establish, consistent with federal
8 requirements for nursing facilities participating in the medicaid
9 program, an appeals or exception procedure that allows individual
10 nursing home providers an opportunity to receive prompt administrative
11 review of payment rates with respect to such issues as the department
12 deems appropriate.

13 (12) The department shall have authority to adopt, amend, and
14 rescind such administrative rules and definitions as it deems necessary
15 to carry out the policies and purposes of this chapter.

16 NEW SECTION. **Sec. 18.** The following acts or parts of acts are
17 each repealed:

18 (1) RCW 74.46.030 (Principles of reporting requirements) and 1980
19 c 177 s 3;

20 (2) RCW 74.46.040 (Due dates for cost reports) and 1998 c 322 s 3,
21 1985 c 361 s 4, 1983 1st ex.s. c 67 s 1, & 1980 c 177 s 4;

22 (3) RCW 74.46.050 (Improperly completed or late cost report--
23 Fines--Adverse rate actions--Rules) and 1998 c 322 s 4, 1985 c 361 s 5,
24 & 1980 c 177 s 5;

25 (4) RCW 74.46.060 (Completing cost reports and maintaining records)
26 and 1998 c 322 s 5, 1985 c 361 s 6, 1983 1st ex.s. c 67 s 2, & 1980 c
27 177 s 6;

28 (5) RCW 74.46.080 (Requirements for retention of records by the
29 contractor) and 1998 c 322 s 6, 1985 c 361 s 7, 1983 1st ex.s. c 67 s
30 3, & 1980 c 177 s 8;

31 (6) RCW 74.46.090 (Retention of cost reports and resident
32 assessment information by the department) and 1998 c 322 s 7, 1985 c
33 361 s 8, & 1980 c 177 s 9;

34 (7) RCW 74.46.100 (Purposes of department audits--Examination--
35 Incomplete or incorrect reports--Contractor's duties--Access to
36 facility--Fines--Adverse rate actions) and 1998 c 322 s 8, 1985 c 361
37 s 9, 1983 1st ex.s. c 67 s 4, & 1980 c 177 s 10;

1 (8) RCW 74.46.155 (Reconciliation of medicaid resident days to
2 billed days and medicaid payments--Payments due--Accrued interest--
3 Withholding funds) and 1998 c 322 s 9;

4 (9) RCW 74.46.165 (Proposed settlement report--Payment refunds--
5 Overpayments--Determination of unused rate funds--Total and component
6 payment rates) and 2001 1st sp.s. c 8 s 2 & 1998 c 322 s 10;

7 (10) RCW 74.46.190 (Principles of allowable costs) and 1998 c 322
8 s 11, 1995 1st sp.s. c 18 s 96, 1983 1st ex.s. c 67 s 12, & 1980 c 177
9 s 19;

10 (11) RCW 74.46.200 (Offset of miscellaneous revenues) and 1980 c
11 177 s 20;

12 (12) RCW 74.46.220 (Payments to related organizations--Limits--
13 Documentation) and 1998 c 322 s 12 & 1980 c 177 s 22;

14 (13) RCW 74.46.230 (Initial cost of operation) and 1998 c 322 s 13,
15 1993 sp.s. c 13 s 3, & 1980 c 177 s 23;

16 (14) RCW 74.46.240 (Education and training) and 1980 c 177 s 24;

17 (15) RCW 74.46.250 (Owner or relative--Compensation) and 1980 c 177
18 s 25;

19 (16) RCW 74.46.270 (Disclosure and approval or rejection of cost
20 allocation) and 1998 c 322 s 14, 1983 1st ex.s. c 67 s 13, & 1980 c 177
21 s 27;

22 (17) RCW 74.46.280 (Management fees, agreements--Limitation on
23 scope of services) and 1998 c 322 s 15, 1993 sp.s. c 13 s 4, & 1980 c
24 177 s 28;

25 (18) RCW 74.46.290 (Expense for construction interest) and 1980 c
26 177 s 29;

27 (19) RCW 74.46.300 (Operating leases of office equipment--Rules)
28 and 1998 c 322 s 16 & 1980 c 177 s 30;

29 (20) RCW 74.46.310 (Capitalization) and 1983 1st ex.s. c 67 s 16 &
30 1980 c 177 s 31;

31 (21) RCW 74.46.320 (Depreciation expense) and 1980 c 177 s 32;

32 (22) RCW 74.46.330 (Depreciable assets) and 1980 c 177 s 33;

33 (23) RCW 74.46.340 (Land, improvements--Depreciation) and 1980 c
34 177 s 34;

35 (24) RCW 74.46.350 (Methods of depreciation) and 1999 c 353 s 13 &
36 1980 c 177 s 35;

37 (25) RCW 74.46.360 (Cost basis of land and depreciation base of

1 depreciable assets) and 1999 c 353 s 2, 1997 c 277 s 1, 1991 sp.s. c 8
2 s 18, & 1989 c 372 s 14;

3 (26) RCW 74.46.370 (Lives of assets) and 1999 c 353 s 14, 1997 c
4 277 s 2, & 1980 c 177 s 37;

5 (27) RCW 74.46.380 (Depreciable assets) and 1993 sp.s. c 13 s 5,
6 1991 sp.s. c 8 s 12, & 1980 c 177 s 38;

7 (28) RCW 74.46.390 (Gains and losses upon replacement of
8 depreciable assets) and 1980 c 177 s 39;

9 (29) RCW 74.46.410 (Unallowable costs) and 2007 c 508 s 1, 2001 1st
10 sp.s. c 8 s 3, 1998 c 322 s 17, 1995 1st sp.s. c 18 s 97, 1993 sp.s. c
11 13 s 6, 1991 sp.s. c 8 s 15, 1989 c 372 s 2, 1986 c 175 s 3, 1983 1st
12 ex.s. c 67 s 17, & 1980 c 177 s 41;

13 (30) RCW 74.46.433 (Variable return component rate allocation) and
14 2006 c 258 s 3, 2001 1st sp.s. c 8 s 6, & 1999 c 353 s 9;

15 (31) RCW 74.46.445 (Contractors--Rate adjustments) and 1999 c 353
16 s 15;

17 (32) RCW 74.46.533 (Combined and estimated rebased rates--
18 Determination--Hold harmless provision) and 2007 c 508 s 6;

19 (33) RCW 74.46.600 (Billing period) and 1980 c 177 s 60;

20 (34) RCW 74.46.610 (Billing procedure--Rules) and 1998 c 322 s 32,
21 1983 1st ex.s. c 67 s 33, & 1980 c 177 s 61;

22 (35) RCW 74.46.620 (Payment) and 1998 c 322 s 33 & 1980 c 177 s 62;

23 (36) RCW 74.46.625 (Supplemental payments) and 1999 c 392 s 1;

24 (37) RCW 74.46.630 (Charges to patients) and 1998 c 322 s 34 & 1980
25 c 177 s 63;

26 (38) RCW 74.46.640 (Suspension of payments) and 1998 c 322 s 35,
27 1995 1st sp.s. c 18 s 112, 1983 1st ex.s. c 67 s 34, & 1980 c 177 s 64;

28 (39) RCW 74.46.650 (Termination of payments) and 1998 c 322 s 36 &
29 1980 c 177 s 65;

30 (40) RCW 74.46.660 (Conditions of participation) and 1998 c 322 s
31 37, 1992 c 215 s 1, 1991 sp.s. c 8 s 13, & 1980 c 177 s 66;

32 (41) RCW 74.46.680 (Change of ownership--Assignment of department's
33 contract) and 1998 c 322 s 38, 1985 c 361 s 2, & 1980 c 177 s 68;

34 (42) RCW 74.46.690 (Change of ownership--Final reports--Settlement)
35 and 1998 c 322 s 39, 1995 1st sp.s. c 18 s 113, 1985 c 361 s 3, 1983
36 1st ex.s. c 67 s 36, & 1980 c 177 s 69;

37 (43) RCW 74.46.700 (Resident personal funds--Records--Rules) and
38 1991 sp.s. c 8 s 19 & 1980 c 177 s 70;

1 (44) RCW 74.46.711 (Resident personal funds--Conveyance upon death
2 of resident) and 2001 1st sp.s. c 8 s 14 & 1995 1st sp.s. c 18 s 69;
3 (45) RCW 74.46.770 (Contractor appeals--Challenges of laws, rules,
4 or contract provisions--Challenge based on federal law) and 1998 c 322
5 s 40, 1995 1st sp.s. c 18 s 114, 1983 1st ex.s. c 67 s 39, & 1980 c 177
6 s 77;
7 (46) RCW 74.46.780 (Appeals or exception procedure) and 1998 c 322
8 s 41, 1995 1st sp.s. c 18 s 115, 1989 c 175 s 159, 1983 1st ex.s. c 67
9 s 40, & 1980 c 177 s 78;
10 (47) RCW 74.46.790 (Denial, suspension, or revocation of license or
11 provisional license--Penalties) and 1980 c 177 s 79;
12 (48) RCW 74.46.820 (Public disclosure) and 2005 c 274 s 356, 1998
13 c 322 s 43, 1985 c 361 s 14, 1983 1st ex.s. c 67 s 41, & 1980 c 177 s
14 82;
15 (49) RCW 74.46.900 (Severability--1980 c 177) and 1980 c 177 s 93;
16 (50) RCW 74.46.901 (Effective dates--1983 1st ex.s. c 67; 1980 c
17 177) and 1983 1st ex.s. c 67 s 49, 1981 1st ex.s. c 2 s 10, & 1980 c
18 177 s 94;
19 (51) RCW 74.46.902 (Section captions--1980 c 177) and 1980 c 177 s
20 89;
21 (52) RCW 74.46.905 (Severability--1983 1st ex.s. c 67) and 1983 1st
22 ex.s. c 67 s 43; and
23 (53) RCW 74.46.906 (Effective date--1998 c 322 §§ 1-37, 40-49, and
24 52-54) and 1998 c 322 s 55.

25 NEW SECTION. **Sec. 19.** This act takes effect July 1, 2010.

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