
HOUSE BILL 1885

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By Representatives Cody, Morrell, Harris, Ross, Chandler, Johnson, Van De Wege, Ryu, Tharinger, and Santos

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1 AN ACT Relating to restoring some of the nursing facility payment
2 methodology changes made during 2011; amending RCW 74.46.431,
3 74.46.435, 74.46.437, 74.46.485, 74.46.501, 74.46.506, 74.46.515, and
4 74.46.521; adding a new section to chapter 74.46 RCW; providing an
5 effective date; and declaring an emergency.

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

7 **Sec. 1.** RCW 74.46.431 and 2011 1st sp.s. c 7 s 1 are each amended
8 to read as follows:

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

15 (2) Component rate allocations in therapy care and support services
16 for all facilities shall be based upon a minimum facility occupancy of
17 eighty-five percent of licensed beds, regardless of how many beds are
18 set up or in use. Component rate allocations in operations, property,
19 and financing allowance for essential community providers shall be

1 based upon a minimum facility occupancy of (~~eighty-seven~~) eighty-five
2 percent of licensed beds, regardless of how many beds are set up or in
3 use. Component rate allocations in operations, property, and financing
4 allowance for small nonessential community providers shall be based
5 upon a minimum facility occupancy of ninety(~~-two~~) percent of licensed
6 beds, regardless of how many beds are set up or in use. Component rate
7 allocations in operations, property, and financing allowance for large
8 nonessential community providers shall be based upon a minimum facility
9 occupancy of (~~ninety-five~~) ninety-two percent of licensed beds,
10 regardless of how many beds are set up or in use. For all facilities,
11 the component rate allocation in direct care shall be based upon actual
12 facility occupancy. The median cost limits used to set component rate
13 allocations shall be based on the applicable minimum occupancy
14 percentage. In determining each facility's therapy care component rate
15 allocation under RCW 74.46.511, the department shall apply the
16 applicable minimum facility occupancy adjustment before creating the
17 array of facilities' adjusted therapy costs per adjusted resident day.
18 In determining each facility's support services component rate
19 allocation under RCW 74.46.515(3), the department shall apply the
20 applicable minimum facility occupancy adjustment before creating the
21 array of facilities' adjusted support services costs per adjusted
22 resident day. In determining each facility's operations component rate
23 allocation under RCW 74.46.521(3), the department shall apply the
24 minimum facility occupancy adjustment before creating the array of
25 facilities' adjusted general operations costs per adjusted resident
26 day.

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

33 (4)(a) Direct care component rate allocations shall be established
34 using adjusted cost report data covering at least six months.
35 Effective July 1, 2009, the direct care component rate allocation shall
36 be rebased, so that adjusted cost report data for calendar year 2007 is
37 used for July 1, 2009, through June 30, 2013. Beginning July 1, 2013,
38 the direct care component rate allocation shall be rebased biennially

1 during every odd-numbered year thereafter using adjusted cost report
2 data from two years prior to the rebase period, so adjusted cost report
3 data for calendar year 2011 is used for July 1, 2013, through June 30,
4 2015, and so forth.

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

19 (5)(a) Therapy care component rate allocations shall be established
20 using adjusted cost report data covering at least six months.
21 Effective July 1, 2009, the therapy care component rate allocation
22 shall be cost rebased, so that adjusted cost report data for calendar
23 year 2007 is used for July 1, 2009, through June 30, 2013. Beginning
24 July 1, 2013, the therapy care component rate allocation shall be
25 rebased biennially during every odd-numbered year thereafter using
26 adjusted cost report data from two years prior to the rebase period, so
27 adjusted cost report data for calendar year 2011 is used for July 1,
28 2013, through June 30, 2015, and so forth.

29 (b) Therapy care component rate allocations established in
30 accordance with this chapter shall be adjusted annually for economic
31 trends and 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 therapy care component rate allocation established in accordance
37 with this chapter. When no economic trends and conditions factor or
38 factors for either fiscal year are defined in a biennial appropriations

1 act, no economic trends and conditions factor or factors defined in any
2 earlier biennial appropriations act shall be applied solely or
3 compounded to the therapy care component rate allocation established in
4 accordance with this chapter.

5 (6)(a) Support services component rate allocations shall be
6 established using adjusted cost report data covering at least six
7 months. Effective July 1, 2009, the support services component rate
8 allocation shall be cost rebased, so that adjusted cost report data for
9 calendar year 2007 is used for July 1, 2009, through June 30, 2013.
10 Beginning July 1, 2013, the support services component rate allocation
11 shall be rebased biennially during every odd-numbered year thereafter
12 using adjusted cost report data from two years prior to the rebase
13 period, so adjusted cost report data for calendar year 2011 is used for
14 July 1, 2013, through June 30, 2015, and so forth.

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

29 (7)(a) Operations component rate allocations shall be established
30 using adjusted cost report data covering at least six months.
31 Effective July 1, 2009, the operations component rate allocation shall
32 be cost rebased, so that adjusted cost report data for calendar year
33 2007 is used for July 1, 2009, through June 30, 2013. Beginning July
34 1, 2013, the operations care component rate allocation shall be rebased
35 biennially during every odd-numbered year thereafter using adjusted
36 cost report data from two years prior to the rebase period, so adjusted
37 cost report data for calendar year 2011 is used for July 1, 2013,
38 through June 30, 2015, and so forth.

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

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

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

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

35 (11) Effective July 1, 2010, there shall be no rate adjustment for
36 facilities with banked beds. For purposes of calculating minimum
37 occupancy, licensed beds include any beds banked under chapter 70.38
38 RCW.

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

9 **Sec. 2.** RCW 74.46.435 and 2011 1st sp.s. c 7 s 2 are each amended
10 to read as follows:

11 (1) The property component rate allocation for each facility shall
12 be determined by dividing the sum of the reported allowable prior
13 period actual depreciation, subject to department rule, adjusted for
14 any capitalized additions or replacements approved by the department,
15 and the retained savings from such cost center, by the greater of a
16 facility's total resident days in the prior period or resident days as
17 calculated on (~~eighty-seven~~) eighty-five percent facility occupancy
18 for essential community providers, ninety(~~-two~~) percent occupancy for
19 small nonessential community providers, or (~~ninety-five~~) ninety-two
20 percent facility occupancy for large nonessential community providers.
21 If a capitalized addition or retirement of an asset will result in a
22 different licensed bed capacity during the ensuing period, the prior
23 period total resident days used in computing the property component
24 rate shall be adjusted to anticipated resident day level.

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

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

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

35 **Sec. 3.** RCW 74.46.437 and 2011 1st sp.s. c 7 s 3 are each amended
36 to read as follows:

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

6 (2) The financing allowance is determined by multiplying the net
7 invested funds of each facility by (~~(.04)~~) .085, and dividing by the
8 greater of a nursing facility's total resident days from the most
9 recent cost report period or resident days calculated on (~~(eighty-~~
10 ~~seven)~~) eighty-five percent facility occupancy for essential community
11 providers, ninety(~~(-two)~~) percent facility occupancy for small
12 nonessential community providers, or (~~(ninety-five)~~) ninety-two percent
13 occupancy for large nonessential community providers. If a capitalized
14 addition, renovation, replacement, or retirement of an asset will
15 result in a different licensed bed capacity during the ensuing period,
16 the prior period total resident days used in computing the financing
17 allowance shall be adjusted to the greater of the anticipated resident
18 day level or (~~(eighty-seven)~~) eighty-five percent of the new licensed
19 bed capacity for essential community providers, ninety(~~(-two)~~) percent
20 facility occupancy for small nonessential community providers, or
21 (~~(ninety-five)~~) ninety-two percent occupancy for large nonessential
22 community providers.

23 (3) In computing the portion of net invested funds representing the
24 net book value of tangible fixed assets, the same assets, depreciation
25 bases, lives, and methods referred to in department rule, including
26 owned and leased assets, shall be utilized, except that the capitalized
27 cost of land upon which the facility is located and such other
28 contiguous land which is reasonable and necessary for use in the
29 regular course of providing resident care must also be included.
30 Subject to provisions and limitations contained in this chapter, for
31 land purchased by owners or lessors before July 18, 1984, capitalized
32 cost of land is the buyer's capitalized cost. For all partial or whole
33 rate periods after July 17, 1984, if the land is purchased after July
34 17, 1984, capitalized cost is that of the owner of record on July 17,
35 1984, or buyer's capitalized cost, whichever is lower. In the case of
36 leased facilities where the net invested funds are unknown or the
37 contractor is unable to provide necessary information to determine net

1 invested funds, the secretary has the authority to determine an amount
2 for net invested funds based on an appraisal conducted according to
3 department rule.

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

7 **Sec. 4.** RCW 74.46.485 and 2011 1st sp.s. c 7 s 4 are each amended
8 to read as follows:

9 (1) The department shall:

10 (a) Employ the resource utilization group III case mix
11 classification methodology. The department shall use the forty-four
12 group index maximizing model for the resource utilization group III
13 grouper version 5.10, but the department may revise or update the
14 classification methodology to reflect advances or refinements in
15 resident assessment or classification, subject to federal
16 requirements(~~(. The department may adjust the case mix index for any~~
17 ~~of the lowest ten resource utilization group categories beginning with~~
18 ~~PA1 through PE2 to any case mix index that aids in achieving the~~
19 ~~purpose and intent of RCW 74.39A.007 and cost efficient care)); and~~

20 (b) Implement minimum data set 3.0 under the authority of this
21 section and RCW 74.46.431(3). The department must notify nursing home
22 contractors twenty-eight days in advance the date of implementation of
23 the minimum data set 3.0. In the notification, the department must
24 identify for all semiannual rate settings following the date of minimum
25 data set 3.0 implementation a previously established semiannual case
26 mix adjustment established for the semiannual rate settings that will
27 be used for semiannual case mix calculations in direct care until
28 minimum data set 3.0 is fully implemented.

29 (2) A default case mix group shall be established for cases in
30 which the resident dies or is discharged for any purpose prior to
31 completion of the resident's initial assessment. The default case mix
32 group and case mix weight for these cases shall be designated by the
33 department.

34 (3) A default case mix group may also be established for cases in
35 which there is an untimely assessment for the resident. The default
36 case mix group and case mix weight for these cases shall be designated
37 by the department.

1 **Sec. 5.** RCW 74.46.501 and 2011 1st sp.s. c 7 s 6 are each amended
2 to read 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) In determining the number of days a resident is classified into
25 a particular case mix group, the department shall determine a start
26 date for calculating case mix grouping periods as specified by rule.

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

33 (6)(a) Although the facility average and the medicaid average case
34 mix indexes shall both be calculated quarterly, the cost-rebasing
35 period facility average case mix index will be used throughout the
36 applicable cost-rebasing period in combination with cost report data as
37 specified by RCW 74.46.431 and 74.46.506, to establish a facility's
38 allowable cost per case mix unit. To allow for the transition to

1 minimum data set 3.0 and implementation of resource utilization group
2 IV for July 1, 2011, through June 30, 2013, the department shall
3 calculate rates using the medicaid average case mix scores effective
4 for January 1, 2011, rates (~~(adjusted under RCW 74.46.485(1)(a),)~~) and
5 the scores shall be increased each six months during the transition
6 period by one-half of one percent. The July 1, 2013, direct care cost
7 per case mix unit shall be calculated by utilizing 2011 direct care
8 costs, patient days, and 2011 facility average case mix indexes based
9 on the minimum data set 3.0 resource utilization group IV grouper 57.
10 A facility's medicaid average case mix index shall be used to update a
11 nursing facility's direct care component rate semiannually.

12 (b) The facility average case mix index used to establish each
13 nursing facility's direct care component rate shall be based on an
14 average of calendar quarters of the facility's average case mix indexes
15 from the four calendar quarters occurring during the cost report period
16 used to rebase the direct care component rate allocations as specified
17 in RCW 74.46.431.

18 (c) The medicaid average case mix index used to update or
19 recalibrate a nursing facility's direct care component rate
20 semiannually shall be from the calendar six-month period commencing
21 nine months prior to the effective date of the semiannual rate. For
22 example, July 1, 2010, through December 31, 2010, direct care component
23 rates shall utilize case mix averages from the October 1, 2009, through
24 March 31, 2010, calendar quarters, and so forth.

25 **Sec. 6.** RCW 74.46.506 and 2011 1st sp.s. c 7 s 7 are each amended
26 to read as follows:

27 (1) The direct care component rate allocation corresponds to the
28 provision of nursing care for one resident of a nursing facility for
29 one day, including direct care supplies. Therapy services and
30 supplies, which correspond to the therapy care component rate, shall be
31 excluded. The direct care component rate includes elements of case mix
32 determined consistent with the principles of this section and other
33 applicable provisions of this chapter.

34 (2) The department shall determine and update semiannually for each
35 nursing facility serving medicaid residents a facility-specific per-
36 resident day direct care component rate allocation, to be effective on
37 the first day of each six-month period. In determining direct care

1 component rates the department shall utilize, as specified in this
2 section, minimum data set resident assessment data for each resident of
3 the facility, as transmitted to, and if necessary corrected by, the
4 department in the resident assessment instrument format approved by
5 federal authorities for use in this state.

6 (3) The department may question the accuracy of assessment data for
7 any resident and utilize corrected or substitute information, however
8 derived, in determining direct care component rates. The department is
9 authorized to impose civil fines and to take adverse rate actions
10 against a contractor, as specified by the department in rule, in order
11 to obtain compliance with resident assessment and data transmission
12 requirements and to ensure accuracy.

13 (4) Cost report data used in setting direct care component rate
14 allocations shall be for rate periods as specified in RCW
15 74.46.431(4)(a).

16 (5) The department shall rebase each nursing facility's direct care
17 component rate allocation as described in RCW 74.46.431, adjust its
18 direct care component rate allocation for economic trends and
19 conditions as described in RCW 74.46.431, and update its medicaid
20 average case mix index as described in RCW 74.46.496 and 74.46.501,
21 consistent with the following:

22 (a) Adjust total direct care costs reported by each nursing
23 facility for the applicable cost report period specified in RCW
24 74.46.431(4)(a) to reflect any department adjustments, and to eliminate
25 reported resident therapy costs and adjustments, in order to derive the
26 facility's total allowable direct care cost;

27 (b) Divide each facility's total allowable direct care cost by its
28 adjusted resident days for the same report period, to derive the
29 facility's allowable direct care cost per resident day;

30 (c) Divide each facility's adjusted allowable direct care cost per
31 resident day by the facility average case mix index for the applicable
32 quarters specified by RCW 74.46.501(6)(b) to derive the facility's
33 allowable direct care cost per case mix unit;

34 (d) Divide nursing facilities into at least two and, if applicable,
35 three peer groups: Those located in nonurban counties; those located
36 in high labor-cost counties, if any; and those located in other urban
37 counties;

1 (e) Array separately the allowable direct care cost per case mix
2 unit for all facilities in nonurban counties; for all facilities in
3 high labor-cost counties, if applicable; and for all facilities in
4 other urban counties, and determine the median allowable direct care
5 cost per case mix unit for each peer group;

6 (f) Determine each facility's semiannual direct care component rate
7 as follows:

8 (i) Any facility whose allowable cost per case mix unit is greater
9 than one hundred (~~ten~~) twelve percent of the peer group median
10 established under (e) of this subsection shall be assigned a cost per
11 case mix unit equal to one hundred (~~ten~~) twelve percent of the peer
12 group median, and shall have a direct care component rate allocation
13 equal to the facility's assigned cost per case mix unit multiplied by
14 that facility's medicaid average case mix index from the applicable
15 six-month period specified in RCW 74.46.501(6)(c);

16 (ii) Any facility whose allowable cost per case mix unit is less
17 than or equal to one hundred (~~ten~~) twelve percent of the peer group
18 median established under (e) of this subsection shall have a direct
19 care component rate allocation equal to the facility's allowable cost
20 per case mix unit multiplied by that facility's medicaid average case
21 mix index from the applicable six-month period specified in RCW
22 74.46.501(6)(c).

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

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

33 **Sec. 7.** RCW 74.46.515 and 2011 1st sp.s. c 7 s 8 are each amended
34 to read as follows:

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

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

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

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

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

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

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

25 **Sec. 8.** RCW 74.46.521 and 2011 1st sp.s. c 7 s 9 are each amended
26 to read as follows:

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

34 (2) The department shall determine each medicaid nursing facility's
35 operations component rate allocation using cost report data specified
36 by RCW 74.46.431(7)(a). Operations component rates for essential
37 community providers shall be based upon a minimum occupancy of

1 ((~~eighty-seven~~)) eighty-five percent of licensed beds. Operations
2 component rates for small nonessential community providers shall be
3 based upon a minimum occupancy of ninety(~~-two~~) percent of licensed
4 beds. Operations component rates for large nonessential community
5 providers shall be based upon a minimum occupancy of ((~~ninety-five~~))
6 ninety-two percent of licensed beds.

7 (3) For all calculations and adjustments in this subsection, the
8 department shall use the greater of the facility's actual occupancy or
9 an occupancy equal to ((~~eighty-seven~~)) eighty-five percent for
10 essential community providers, ninety(~~-two~~) percent for small
11 nonessential community providers, or ((~~ninety-five~~)) ninety-two percent
12 for large nonessential community providers. To determine each
13 facility's operations component rate the department shall:

14 (a) Array facilities' adjusted general operations costs per
15 adjusted resident day, as determined by dividing each facility's total
16 allowable operations cost by its adjusted resident days for the same
17 report period for facilities located within urban counties and for
18 those located within nonurban counties and determine the median
19 adjusted cost for each peer group;

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

21 (i) The facility's per resident day adjusted operations costs from
22 the applicable cost report period adjusted if necessary for minimum
23 occupancy; or

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

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

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

32 NEW SECTION. **Sec. 9.** A new section is added to chapter 74.46 RCW
33 to read as follows:

34 (1)(a) The department shall establish for each medicaid nursing
35 facility a medicaid disproportionate share component rate allocation.
36 In determining the disproportionate share component:

1 (i) The disproportionate share percentage shall be assigned
2 annually, commencing with July 1, 2013;

3 (ii) A disproportionate share percentage factor shall be assigned
4 each facility based upon the percentage of medicaid recipients served
5 at the facility as reported in the immediately preceding year's
6 medicaid cost report, in accordance with the following:

7 (A) 75.01 percent to 100 percent assigns a 2.5 percent factor;

8 (B) 50.01 percent to 75.0 percent assigns a 1.5 percent factor;

9 (C) 25.01 percent to 50.0 percent assigns a 0.5 percent factor;

10 (D) Less than 25.0 percent assigns a 0.0 percent factor.

11 (b) The department shall compute the medicaid disproportionate
12 share component rate allocation by multiplying a facility's assigned
13 percentage factor from (a)(ii) of this subsection by the total medicaid
14 payment rate less any safety net assessment component rate allocation
15 determined in accordance with this chapter and rules adopted by the
16 department.

17 (c) The medicaid disproportionate share component rate allocation
18 is not subject to the reconciliation and settlement process provided
19 for in RCW 74.46.022(6).

20 (2) The medicaid disproportionate share component rate allocation
21 calculated in accordance with this section shall be adjusted to the
22 extent necessary to comply with RCW 74.46.421.

23 NEW SECTION. **Sec. 10.** This act is necessary for the immediate
24 preservation of the public peace, health, or safety, or support of the
25 state government and its existing public institutions, and takes effect
26 July 1, 2013.

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