CERTIFICATION OF ENROLLMENT

SUBSTITUTE HOUSE BILL 2678

64th Legislature
2016 Regular Session

Passed by the House February 11, 2016
Yeas 96 Nays 1

Speaker of the House of Representatives

Passed by the Senate March 1, 2016
Yeas 46 Nays 0

President of the Senate

Approved

Governor of the State of Washington

CERTIFICATE

I, Barbara Baker, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **SUBSTITUTE HOUSE BILL 2678** as passed by House of Representatives and the Senate on the dates hereon set forth.

Chief Clerk

FILED

Secretary of State
State of Washington

SUBSTITUTE HOUSE BILL 2678

Passed Legislature - 2016 Regular Session

State of Washington 64th Legislature 2016 Regular Session

By House Appropriations (originally sponsored by Representatives Schmick, Cody, and Van De Wege)

READ FIRST TIME 02/02/16.

AN ACT Relating to nursing home facilities; amending RCW 74.46.561, 74.42.360, 74.46.020, 74.46.501, 74.46.835, and 74.46.581; reenacting and amending RCW 74.42.010; repealing RCW 74.46.803, 74.46.807, 74.46.437, and 74.46.439; and prescribing penalties.

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

Sec. 1. RCW 74.46.561 and 2015 2nd sp.s. c 2 s 4 are each amended to read as follows:

(1) The legislature adopts a new system for establishing nursing home payment rates beginning July 1, 2016. Any payments to nursing homes for services provided after June 30, 2016, must be based on the new system. The new system must be designed in such a manner as to decrease administrative complexity associated with the payment methodology, reward nursing homes providing care for high acuity residents, incentivize quality care for residents of nursing homes, and establish minimum staffing standards for direct care.

(2) The new system must be based primarily on industry-wide costs, and have three main components: Direct care, indirect care, and capital.

(3) The direct care component must include the direct care and therapy care components of the previous system, along with food, laundry, and dietary services. Direct care must be paid at a fixed

rate, based on one hundred percent or greater of ((~~facility-wide~~)) statewide case mix neutral median costs. Direct care must be performance-adjusted for acuity every six months, using case mix principles. Direct care must be regionally adjusted ((~~for nonmetropolitan and metropolitan statistical areas~~)) using county wide wage index information available through the United States department of labor's bureau of labor statistics. There is no minimum occupancy for direct care. The direct care component rate allocations calculated in accordance with this section must be adjusted to the extent necessary to comply with RCW 74.46.421.

(4) The indirect care component must include the elements of administrative expenses, maintenance costs, and housekeeping services from the previous system. A minimum occupancy assumption of ninety percent must be applied to indirect care. Indirect care must be paid at a fixed rate, based on ninety percent or greater of ((~~facility-wide~~)) statewide median costs. ((~~Indirect care must be regionally adjusted for nonmetropolitan and metropolitan statistical areas.~~)) The indirect care component rate allocations calculated in accordance with this section must be adjusted to the extent necessary to comply with RCW 74.46.421.

(5) The capital component must use a fair market rental system to set a price per bed. The capital component must be adjusted for the age of the facility, and must use a minimum occupancy assumption of ninety percent.

(a) Beginning July 1, 2016, the fair rental rate allocation for each facility must be determined by multiplying the allowable nursing home square footage in (c) of this subsection by the RS means rental rate in (d) of this subsection and by the number of licensed beds yielding the gross unadjusted building value. An equipment allowance of ten percent must be added to the unadjusted building value. The sum of the unadjusted building value and equipment allowance must then be reduced by the average age of the facility as determined by (e) of this subsection using a depreciation rate of one and one-half percent. The depreciated building and equipment plus land valued at ten percent of the gross unadjusted building value before depreciation must then be multiplied by the rental rate at seven and one-half percent to yield an allowable fair rental value for the land, building, and equipment.

(b) The fair rental value determined in (a) of this subsection must be divided by the greater of the actual total facility census

from the prior full calendar year or imputed census based on the number of licensed beds at ninety percent occupancy.

(c) For the rate year beginning July 1, 2016, all facilities must be reimbursed using four hundred square feet. For the rate year beginning July 1, 2017, allowable nursing facility square footage must be determined using the total nursing facility square footage as reported on the medicaid cost reports submitted to the department in compliance with this chapter. The maximum allowable square feet per bed may not exceed four hundred fifty.

(d) Each facility must be paid at eighty-three percent or greater of the median nursing facility RS means construction index value per square foot for Washington state. The department may use updated RS means construction index information when more recent square footage data becomes available. The statewide value per square foot must be indexed based on facility zip code by multiplying the statewide value per square foot times the appropriate zip code based index. For the purpose of implementing this section, the value per square foot effective July 1, 2016, must be set so that the weighted average FRV rate is not less than ten dollars and eighty cents ppd. The capital component rate allocations calculated in accordance with this section must be adjusted to the extent necessary to comply with RCW 74.46.421.

(e) The average age is the actual facility age reduced for significant renovations. Significant renovations are defined as those renovations that exceed two thousand dollars per bed in a calendar year as reported on the annual cost report submitted in accordance with this chapter. For the rate beginning July 1, 2016, the department shall use renovation data back to 1994 as submitted on facility cost reports. Beginning July 1, 2016, facility ages must be reduced in future years if the value of the renovation completed in any year exceeds two thousand dollars times the number of licensed beds. The cost of the renovation must be divided by the accumulated depreciation per bed in the year of the renovation to determine the equivalent number of new replacement beds. The new age for the facility is a weighted average with the replacement bed equivalents reflecting an age of zero and the existing licensed beds, minus the new bed equivalents, reflecting their age in the year of the renovation. At no time may the depreciated age be less than zero or greater than forty-four years.

(f) A nursing facility's capital component rate allocation must be rebased annually, effective July 1, 2016, in accordance with this section and this chapter.

(6) A quality incentive must be offered as a rate enhancement beginning July 1, 2016.

(a) An enhancement no larger than five percent and no less than one percent of the statewide average daily rate must be paid to facilities that meet or exceed the standard established for the quality incentive. All providers must have the opportunity to earn the full quality incentive payment. ((~~The department must recommend four to six measures to become the standard for the quality incentive, and must describe a system for rewarding incremental improvement related to these four to six measures, within the report to the legislature described in section 6, chapter 2, Laws of 2015 2nd sp. sess. Infection rates, pressure ulcers, staffing turnover, fall prevention, utilization of antipsychotic medication, and hospital readmission rates are examples of measures that may be established for the quality incentive.~~))

(b) The quality incentive component must be determined by calculating an overall facility quality score composed of four to six quality measures. For fiscal year 2017 there shall be four quality measures, and for fiscal year 2018 there shall be six quality measures. Initially, the quality incentive component must be based on minimum data set quality measures for the percentage of long-stay residents who self-report moderate to severe pain, the percentage of high-risk long-stay residents with pressure ulcers, the percentage of long-stay residents experiencing one or more falls with major injury, and the percentage of long-stay residents with a urinary tract infection. Quality measures must be reviewed on an annual basis by a stakeholder work group established by the department. Upon review, quality measures may be added or changed. The department may risk adjust individual quality measures as it deems appropriate.

(c) The facility quality score must be point based, using at a minimum the facility's most recent available three-quarter average CMS quality data. Point thresholds for each quality measure must be established using the corresponding statistical values for the quality measure (QM) point determinants of eighty QM points, sixty QM points, forty QM points, and twenty QM points, identified in the most recent available five-star quality rating system technical user's guide published by the center for medicare and medicaid services.

(d) Facilities meeting or exceeding the highest performance threshold (Top level) for a quality measure receive twenty-five points. Facilities meeting the second highest performance threshold receive twenty points. Facilities meeting the third level of performance threshold receive fifteen points. Facilities in the bottom performance threshold level receive no points. Points from all quality measures must then be summed into a single aggregate quality score for each facility.

(e) Facilities receiving an aggregate quality score of eighty percent of the overall available total score or higher must be placed in the highest tier (Tier V), facilities receiving an aggregate score of between seventy and seventy-nine percent of the overall available total score must be placed in the second highest tier (Tier IV), facilities receiving an aggregate score of between sixty and sixty-nine percent of the overall available total score must be placed in the third highest tier (Tier III), facilities receiving an aggregate score of between fifty and fifty-nine percent of the overall available total score must be placed in the fourth highest tier (Tier II), and facilities receiving less than fifty percent of the overall available total score must be placed in the lowest tier (Tier I).

(f) The tier system must be used to determine the amount of each facility's per patient day quality incentive component. The per patient day quality incentive component for Tier IV is seventy-five percent of the per patient day quality incentive component for Tier V, the per patient day quality incentive component for Tier III is fifty percent of the per patient day quality incentive component for Tier V, and the per patient day quality incentive component for Tier II is twenty-five percent of the per patient day quality incentive component for Tier V. Facilities in Tier I receive no quality incentive component.

(g) Tier system payments must be set in a manner that ensures that the entire biennial appropriation for the quality incentive program is allocated.

(h) Facilities with insufficient three-quarter average CMS quality data must be assigned to the tier corresponding to their five-star quality rating. Facilities with a five-star quality rating must be assigned to the highest tier (Tier V) and facilities with a one-star quality rating must be assigned to the lowest tier (Tier I). The use of a facility's five-star quality rating shall only occur in the case of insufficient CMS minimum data set information.

(i) The quality incentive rates must be adjusted semiannually on July 1 and January 1 of each year using, at a minimum, the most recent available three-quarter average CMS quality data.

(j) Beginning July 1, 2017, the percentage of short-stay residents who newly received an antipsychotic medication must be added as a quality measure. The department must determine the quality incentive thresholds for this quality measure in a manner consistent with those outlined in (b) through (h) of this subsection using the centers for medicare and medicaid services quality data.

(k) Beginning July 1, 2017, the percentage of direct care staff turnover must be added as a quality measure using the centers for medicare and medicaid services' payroll-based journal and nursing home facility payroll data. Turnover is defined as an employee departure. The department must determine the quality incentive thresholds for this quality measure using data from the centers for medicare and medicaid services' payroll-based journal, unless such data is not available, in which case the department shall use direct care staffing turnover data from the most recent medicaid cost report.

(7) Reimbursement of the safety net assessment imposed by chapter 74.48 RCW and paid in relation to medicaid residents must be continued.

(8) The direct care and indirect care components must be rebased in even-numbered years, beginning with rates paid on July 1, 2016. Rates paid on July 1, 2016, must be based on the 2014 calendar year cost report. On a percentage basis, after rebasing, the department must confirm that the statewide average daily rate has increased at least as much as the average rate of inflation, as determined by the skilled nursing facility market basket index published by the centers for medicare and medicaid services, or a comparable index. If after rebasing, the percentage increase to the statewide average daily rate is less than the average rate of inflation for the same time period, the department is authorized to increase rates by the difference between the percentage increase after rebasing and the average rate of inflation.

(9) The direct care component provided in subsection (3) of this section is subject to the reconciliation and settlement process provided in RCW 74.46.022(6). Beginning July 1, 2016, pursuant to rules established by the department, funds that are received through the reconciliation and settlement process provided in RCW

74.46.022(6) must be used for technical assistance, specialized training, or an increase to the quality enhancement established in subsection (6) of this section. The legislature intends to review the utility of maintaining the reconciliation and settlement process under a price-based payment methodology, and may discontinue the reconciliation and settlement process after the 2017-2019 fiscal biennium.

(10) Compared to the rate in effect June 30, 2016, including all cost components and rate add-ons, no facility may receive a rate reduction of more than one percent on July 1, 2016, more than two percent on July 1, 2017, or more than five percent on July 1, 2018. To ensure that the appropriation for nursing homes remains cost neutral, the department is authorized to cap the rate increase for facilities in fiscal years 2017, 2018, and 2019.

Sec. 2. RCW 74.42.360 and 2015 2nd sp.s. c 2 s 7 are each amended to read as follows:

(1) The facility shall have staff on duty twenty-four hours daily sufficient in number and qualifications to carry out the provisions of RCW 74.42.010 through 74.42.570 and the policies, responsibilities, and programs of the facility.

(2) The department shall institute minimum staffing standards for nursing homes. Beginning July 1, 2016, facilities must provide a minimum of 3.4 hours per resident day of direct care. Direct care ((~~includes registered nurses, licensed practical nurses, and certified nursing assistants~~)) staff has the same meaning as defined in RCW 74.42.010. The minimum staffing standard includes the time when such staff are providing hands-on care related to activities of daily living and nursing-related tasks, as well as care planning. The legislature intends to increase the minimum staffing standard to 4.1 hours per resident day of direct care, but the effective date of a standard higher than 3.4 hours per resident day of direct care will be identified if and only if funding is provided explicitly for an increase of the minimum staffing standard for direct care.

(a) The department shall establish in rule a system of compliance of minimum direct care staffing standards by January 1, 2016. Oversight must be done at least quarterly using the center for medicare and medicaid service's payroll based journal and nursing home facility census and payroll data.

(b) The department shall establish in rule by January 1, 2016, a system of financial penalties for facilities out of compliance with minimum staffing standards. No monetary penalty may be issued during the implementation period of July 1, 2016, through September 30, 2016. If a facility is found noncompliant during the implementation period, the department shall provide a written notice identifying the staffing deficiency and require the facility to provide a sufficiently detailed correction plan to meet the statutory minimum staffing levels. Monetary penalties begin October 1, 2016. Monetary penalties must be established based on a formula that calculates the cost of wages and benefits for the missing staff hours. If a facility meets the requirements in subsection (3) or (4) of this section, the penalty amount must be based solely on the wages and benefits of certified nurse aides. The first monetary penalty for noncompliance must be at a lower amount than subsequent findings of noncompliance. Monetary penalties established by the department may not exceed two hundred percent of the wage and benefit costs that would have otherwise been expended to achieve the required staffing minimum HPRD for the quarter. A facility found out of compliance must be assessed a monetary penalty at the lowest penalty level if the facility has met or exceeded the requirements in subsection (2) of this section for three or more consecutive years. Beginning July 1, 2016, pursuant to rules established by the department, funds that are received from financial penalties must be used for technical assistance, specialized training, or an increase to the quality enhancement established in RCW 74.46.561.

(c) The department shall establish in rule an exception allowing geriatric behavioral health workers as defined in RCW 74.42.010 to be recognized in the minimum staffing requirements as part of the direct care service delivery to individuals suffering from mental illness. In order to qualify for the exception:

(i) The worker must have at least three years experience providing care for individuals with chronic mental health issues, dementia, or intellectual and developmental disabilities in a long-term care or behavioral health care setting;

(ii) The worker must have advanced practice knowledge in aging, disability, mental illness, Alzheimer's disease, and developmental disabilities; and

(iii) Any geriatric behavioral health worker holding less than a master's degree in social work must be directly supervised by an

employee who has a master's degree in social work or a registered nurse.

(d)(i) The department shall establish a limited exception to the 3.4 HPRD staffing requirement for facilities demonstrating a good faith effort to hire and retain staff.

(ii) To determine initial facility eligibility for exception consideration, the department shall send surveys to facilities anticipated to be below, at, or slightly above the 3.4 HPRD requirement. These surveys must measure the HPRD in a manner as similar as possible to the centers for medicare and medicaid services' payroll-based journal and cover the staffing of a facility from October through December of 2015, January through March of 2016, and April through June of 2016. A facility must be below the 3.4 staffing standard on all three surveys to be eligible for exception consideration. If the staffing HPRD for a facility declines from any quarter to another during the survey period, the facility must provide sufficient information to the department to allow the department to determine if the staffing decrease was deliberate or a result of neglect, which is the lack of evidence demonstrating the facility's efforts to maintain or improve its staffing ratio. The burden of proof is on the facility and the determination of whether or not the decrease was deliberate or due to neglect is entirely at the discretion of the department. If the department determines a facility's decline was deliberate or due to neglect, that facility is not eligible for an exception consideration.

(iii) To determine eligibility for exception approval, the department shall review the plan of correction submitted by the facility. Before a facility's exception may be renewed, the department must determine that sufficient progress is being made towards reaching the 3.4 HPRD staffing requirement. When reviewing whether to grant or renew an exception, the department must consider factors including but not limited to: Financial incentives offered by the facilities such as recruitment bonuses and other incentives; the robustness of the recruitment process; county employment data; specific steps the facility has undertaken to improve retention; improvements in the staffing ratio compared to the baseline established in the surveys and whether this trend is continuing; and compliance with the process of submitting staffing data, adherence to the plan of correction, and any progress toward meeting this plan, as determined by the department.

(iv) Only facilities that have their direct care component rate increase capped according to RCW 74.46.561 are eligible for exception consideration. Facilities that will have their direct care component rate increase capped for one or two years are eligible for exception consideration through June 30, 2017. Facilities that will have their direct care component rate increase capped for three years are eligible for exception consideration through June 30, 2018.

(v) The department may not grant or renew a facility's exception if the facility meets the 3.4 HPRD staffing requirement and subsequently drops below the 3.4 HPRD staffing requirement.

(vi) The department may grant exceptions for a six-month period per exception. The department's authority to grant exceptions to the 3.4 HPRD staffing requirement expires June 30, 2018.

(3)(a) Large nonessential community providers must have a registered nurse on duty directly supervising resident care twenty-four hours per day, seven days per week.

(b) The department shall establish a limited exception process to facilities that can demonstrate a good faith effort to hire a registered nurse for the last eight hours of required coverage per day. In granting an exception, the department may consider wages and benefits offered and the availability of registered nurses in the particular geographic area. A one-year exception may be granted and may be renewable for up to three consecutive years; however, the department may limit the admission of new residents, based on medical conditions or complexities, when a registered nurse is not on-site and readily available. If a facility receives an exemption, that information must be included in the department's nursing home locator. After June 30, 2019, the department, along with a stakeholder work group established by the department, shall conduct a review of the exceptions process to determine if it is still necessary.

(4) Essential community providers and small nonessential community providers must have a registered nurse on duty directly supervising resident care a minimum of sixteen hours per day, seven days per week, and a registered nurse or a licensed practical nurse on duty directly supervising resident care the remaining eight hours per day, seven days per week.

Sec. 3. RCW 74.42.010 and 2011 c 228 s 2 and 2011 c 89 s 19 are each reenacted and amended to read as follows:

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

(1) "Department" means the department of social and health services and the department's employees.

(2) "Facility" refers to a nursing home as defined in RCW 18.51.010.

(3) "Licensed practical nurse" means a person licensed to practice practical nursing under chapter 18.79 RCW.

(4) "Medicaid" means Title XIX of the Social Security Act enacted by the social security amendments of 1965 (42 U.S.C. Sec. 1396; 79 Stat. 343), as amended.

(5) "Nurse practitioner" means a person licensed to practice advanced registered nursing under chapter 18.79 RCW.

(6) "Nursing care" means that care provided by a registered nurse, an advanced registered nurse practitioner, a licensed practical nurse, or a nursing assistant in the regular performance of their duties.

(7) "Physician" means a person practicing pursuant to chapter 18.57 or 18.71 RCW, including, but not limited to, a physician employed by the facility as provided in chapter 18.51 RCW.

(8) "Physician assistant" means a person practicing pursuant to chapter 18.57A or 18.71A RCW.

(9) "Qualified therapist" means:

(a) An activities specialist who has specialized education, training, or experience specified by the department.

(b) An audiologist who is eligible for a certificate of clinical competence in audiology or who has the equivalent education and clinical experience.

(c) A mental health professional as defined in chapter 71.05 RCW.

(d) An intellectual disabilities professional who is a qualified therapist or a therapist approved by the department and has specialized training or one year experience in treating or working with persons with intellectual or developmental disabilities.

(e) An occupational therapist who is a graduate of a program in occupational therapy or who has equivalent education or training.

(f) A physical therapist as defined in chapter 18.74 RCW.

(g) A social worker as defined in RCW 18.320.010(2).

(h) A speech pathologist who is eligible for a certificate of clinical competence in speech pathology or who has equivalent education and clinical experience.

(10) "Registered nurse" means a person licensed to practice registered nursing under chapter 18.79 RCW.

(11) "Resident" means an individual residing in a nursing home, as defined in RCW 18.51.010.

(12) "Direct care staff" means the staffing domain identified and defined in the center for medicare and medicaid service's five-star quality rating system and as reported through the center for medicare and medicaid service's payroll-based journal.

(13) "Geriatric behavioral health worker" means a person with a bachelor's or master's degree in social work who has received specialized training devoted to mental illness and treatment of older adults.

(14) "Licensed practical nurse" means a person licensed to practice practical nursing under chapter 18.79 RCW.

Sec. 4. RCW 74.46.020 and 2010 1st sp.s. c 34 s 2 are each amended to read as follows:

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

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

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

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

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

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

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

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

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

(9) ((~~"Certificate of capital authorization" means a certification from the department for an allocation from the biennial capital financing authorization for all new or replacement building construction, or for major renovation projects, receiving a certificate of need or a certificate of need exemption under chapter 70.38 RCW after July 1, 2001.~~

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

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

((~~(12)~~)) (11) "Department" means the department of social and health services (DSHS) and its employees.

((~~(13)~~)) (12) "Depreciation" means the systematic distribution of the cost or other basis of tangible assets, less salvage, over the estimated useful life of the assets.

((~~(14)~~)) (13) "Direct care component" means nursing care and related care provided to nursing facility residents and includes the therapy care component, along with food, laundry, and dietary

services of the previous system. ((~~Therapy care shall not be considered part of direct care.~~

~~(15)~~)) (14) "Direct care supplies" means medical, pharmaceutical, and other supplies required for the direct care of a nursing facility's residents.

((~~(16)~~)) (15) "Entity" means an individual, partnership, corporation, limited liability company, or any other association of individuals capable of entering enforceable contracts.

((~~(17)~~)) (16) "Equity" means the net book value of all tangible and intangible assets less the recorded value of all liabilities, as recognized and measured in conformity with generally accepted accounting principles.

((~~(18)~~)) (17) "Essential community provider" means a facility which is the only nursing facility within a commuting distance radius of at least forty minutes duration, traveling by automobile.

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

((~~(20)~~)) (19) "Fair market value" means the replacement cost of an asset less observed physical depreciation on the date for which the market value is being determined.

((~~(21)~~)) (20) "Financial statements" means statements prepared and presented in conformity with generally accepted accounting principles including, but not limited to, balance sheet, statement of operations, statement of changes in financial position, and related notes.

((~~(22)~~)) (21) "Generally accepted accounting principles" means accounting principles approved by the financial accounting standards board (FASB) or its successor.

((~~(23)~~)) (22) "Grouper" means a computer software product that groups individual nursing facility residents into case mix classification groups based on specific resident assessment data and computer logic.

((~~(24)~~)) (23) "High labor-cost county" means an urban county in which the median allowable facility cost per case mix unit is more than ten percent higher than the median allowable facility cost per case mix unit among all other urban counties, excluding that county.

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

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

((~~(27)~~)) (26) "Large nonessential community providers" means nonessential community providers with more than sixty licensed beds, regardless of how many beds are set up or in use.

((~~(28)~~)) (27) "Lease agreement" means a contract between two parties for the possession and use of real or personal property or assets for a specified period of time in exchange for specified periodic payments. Elimination (due to any cause other than death or divorce) or addition of any party to the contract, expiration, or modification of any lease term in effect on January 1, 1980, or termination of the lease by either party by any means shall constitute a termination of the lease agreement. An extension or renewal of a lease agreement, whether or not pursuant to a renewal provision in the lease agreement, shall be considered a new lease agreement. A strictly formal change in the lease agreement which modifies the method, frequency, or manner in which the lease payments are made, but does not increase the total lease payment obligation of the lessee, shall not be considered modification of a lease term.

((~~(29)~~)) (28) "Medical care program" or "medicaid program" means medical assistance, including nursing care, provided under RCW 74.09.500 or authorized state medical care services.

((~~(30)~~)) (29) "Medical care recipient," "medicaid recipient," or "recipient" means an individual determined eligible by the department for the services provided under chapter 74.09 RCW.

((~~(31)~~)) (30) "Minimum data set" means the overall data component of the resident assessment instrument, indicating the strengths, needs, and preferences of an individual nursing facility resident.

((~~(32)~~)) (31) "Net book value" means the historical cost of an asset less accumulated depreciation.

((~~(33)~~)) (32) "Net invested funds" means the net book value of tangible fixed assets employed by a contractor to provide services

under the medical care program, including land, buildings, and equipment as recognized and measured in conformity with generally accepted accounting principles.

((~~(34)~~)) (33) "Nonurban county" means a county which is not located in a metropolitan statistical area as determined and defined by the United States office of management and budget or other appropriate agency or office of the federal government.

((~~(35)~~)) (34) "Owner" means a sole proprietor, general or limited partners, members of a limited liability company, and beneficial interest holders of five percent or more of a corporation's outstanding stock.

((~~(36)~~)) (35) "Patient day" or "resident day" means a calendar day of care provided to a nursing facility resident, regardless of payment source, which will include the day of admission and exclude the day of discharge; except that, when admission and discharge occur on the same day, one day of care shall be deemed to exist. A "medicaid day" or "recipient day" means a calendar day of care provided to a medicaid recipient determined eligible by the department for services provided under chapter 74.09 RCW, subject to the same conditions regarding admission and discharge applicable to a patient day or resident day of care.

((~~(37)~~)) (36) "Qualified therapist" means:

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

(b) An intellectual disabilities professional who is a therapist approved by the department who has had specialized training or one year's experience in treating or working with persons with intellectual or developmental disabilities;

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

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

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

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

((~~(38)~~)) (37) "Rate" or "rate allocation" means the medicaid per-patient-day payment amount for medicaid patients calculated in accordance with the allocation methodology set forth in part E of this chapter.

((~~(39)~~)) (38) "Rebased rate" or "cost-rebased rate" means a facility-specific component rate assigned to a nursing facility for a particular rate period established on desk-reviewed, adjusted costs reported for that facility covering at least six months of a prior calendar year designated as a year to be used for cost-rebasing payment rate allocations under the provisions of this chapter.

((~~(40)~~)) (39) "Records" means those data supporting all financial statements and cost reports including, but not limited to, all general and subsidiary ledgers, books of original entry, and transaction documentation, however such data are maintained.

((~~(41)~~)) (40) "Resident assessment instrument," including federally approved modifications for use in this state, means a federally mandated, comprehensive nursing facility resident care planning and assessment tool, consisting of the minimum data set and resident assessment protocols.

((~~(42)~~)) (41) "Resident assessment protocols" means those components of the resident assessment instrument that use the minimum data set to trigger or flag a resident's potential problems and risk areas.

((~~(43)~~)) (42) "Resource utilization groups" means a case mix classification system that identifies relative resources needed to care for an individual nursing facility resident.

((~~(44)~~)) (43) "Secretary" means the secretary of the department of social and health services.

((~~(45)~~)) (44) "Small nonessential community providers" means nonessential community providers with sixty or fewer licensed beds, regardless of how many beds are set up or in use.

((~~(46) "Support services" means food, food preparation, dietary, housekeeping, and laundry services provided to nursing facility residents.~~

~~(47)~~)) (45) "Therapy care" means those services required by a nursing facility resident's comprehensive assessment and plan of care, that are provided by qualified therapists, or support personnel under their supervision, including related costs as designated by the department.

((~~(48)~~)) (46) "Title XIX" or "medicaid" means the 1965 amendments to the social security act, P.L. 89-07, as amended and the medicaid program administered by the department.

((~~(49)~~)) (47) "Urban county" means a county which is located in a metropolitan statistical area as determined and defined by the United

States office of management and budget or other appropriate agency or office of the federal government.

(48) "Capital component" means a fair market rental system that sets a price per nursing facility bed.

(49) "Indirect care component" means the elements of administrative expenses, maintenance costs, taxes, and housekeeping services from the previous system.

(50) "Quality enhancement component" means a rate enhancement offered to facilities that meet or exceed the standard established for the quality measures.

Sec. 5. RCW 74.46.501 and 2015 2nd sp.s. c 2 s 2 are each amended to read as follows:

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

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

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

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

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

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

(6)(a) Although the facility average and the medicaid average case mix indexes shall both be calculated quarterly, the cost-rebasing period facility average case mix index will be used throughout the applicable cost-rebasing period in combination with cost report data as specified by RCW ((~~74.46.431 and 74.46.506~~)) 74.46.561, to establish a facility's allowable cost per case mix unit. To allow for the transition to minimum data set 3.0 and implementation of resource utilization group IV for July 1, 2015, through June 30, ((~~2017~~)) 2016, the department shall calculate rates using the medicaid average case mix scores effective for January 1, 2015, rates adjusted under RCW 74.46.485(1)(a), and the scores shall be increased each six months during the transition period by one-half of one percent. The July 1, ((~~2017~~)) 2016, direct care cost per case mix unit shall be calculated by utilizing ((~~2015~~)) 2014 direct care costs, patient days, and ((~~2015~~)) 2014 facility average case mix indexes based on the minimum data set 3.0 resource utilization group IV grouper 57. Otherwise, a facility's medicaid average case mix index shall be used to update a nursing facility's direct care component rate semiannually.

(b) The facility average case mix index used to establish each nursing facility's direct care component rate shall be based on an average of calendar quarters of the facility's average case mix indexes from the four calendar quarters occurring during the cost report period used to rebase the direct care component rate allocations as specified in RCW ((~~74.46.431~~)) 74.46.561.

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

Sec. 6. RCW 74.46.835 and 2010 1st sp.s. c 34 s 17 are each amended to read as follows:

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

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

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

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

Sec. 7. RCW 74.46.581 and 2015 2nd sp.s. c 2 s 8 are each amended to read as follows:

A separate nursing facility quality enhancement account is created in the custody of the state treasurer. Beginning July 1, 2015, all net receipts from the reconciliation and settlement process provided in RCW 74.46.022(6), as described within RCW 74.46.561, must be deposited into the account. Beginning July 1, 2016, all receipts from the system of financial penalties for facilities out of compliance with minimum staffing standards, as described within RCW 74.42.360, must be deposited into the account. Only the secretary, or the secretary's designee, may authorize expenditures from the account. The account is subject to allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures. The department shall use the special account only for technical assistance for nursing facilities, specialized training for nursing facilities, or an increase to the quality enhancement established in RCW 74.46.561, or as necessary for the reconciliation and settlement process, which requires deposits and withdrawals to complete both the preliminary and final settlement net receipt amounts for this account.

NEW SECTION. **Sec. 8.** The following acts or parts of acts are each repealed:

(1) RCW 74.46.803 (Certificate of capital authorization—Rules—Emergency situations) and 2008 c 255 s 1 & 2001 1st sp.s. c 8 s 16;

(2) RCW 74.46.807 (Capital authorization—Determination) and 2008 c 255 s 2 & 2001 1st sp.s. c 8 s 15;

(3) RCW 74.46.437 (Financing allowance component rate allocation) and 2011 1st sp.s. c 7 s 3, 2001 1st sp.s. c 8 s 8, & 1999 c 353 s 11; and

(4) RCW 74.46.439 (Facilities leased in arm's-length agreements—Financing allowance rate—Rate adjustment) and 2010 1st sp.s. c 34 s 7 & 1999 c 353 s 12.

--- END ---