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HOUSE BILL 2716

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By Representatives Fromhold, Kessler, Skinner, Haigh, Strow, Moeller, Armstrong, Conway, Curtis, Murray, Buri, Green, Ericksen, Serben, McDermott, Morrell, McIntire, Appleton, Kenney, P. Sullivan, Ormsby and Linville

Read first time 01/12/2006. Referred to Committee on Appropriations.

1 AN ACT Relating to nursing facility medicaid payment systems;  
2 amending RCW 74.46.020, 74.46.421, 74.46.431, 74.46.506, 74.46.511, and  
3 74.46.521; and adding a new section to chapter 74.46 RCW.

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

5 **Sec. 1.** RCW 74.46.020 and 2001 1st sp.s. c 8 s 1 are each amended  
6 to read as follows:

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

9 (1) "Accrual method of accounting" means a method of accounting in  
10 which revenues are reported in the period when they are earned,  
11 regardless of when they are collected, and expenses are reported in the  
12 period in which they are incurred, regardless of when they are paid.

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

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

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

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

20 (6) "Bad debts" means amounts considered to be uncollectible from  
21 accounts and notes receivable.

22 (7) "Beneficial owner" means:

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

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

27 (ii) Investment power which includes the power to dispose, or to  
28 direct the disposition of such ownership interest;

29 (b) Any person who, directly or indirectly, creates or uses a  
30 trust, proxy, power of attorney, pooling arrangement, or any other  
31 contract, arrangement, or device with the purpose or effect of  
32 divesting himself or herself of beneficial ownership of an ownership  
33 interest or preventing the vesting of such beneficial ownership as part  
34 of a plan or scheme to evade the reporting requirements of this  
35 chapter;

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

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

- 1           (10) "Case mix index" means a number representing the average case  
2 mix of a nursing facility.
- 3           (11) "Case mix weight" means a numeric score that identifies the  
4 relative resources used by a particular group of a nursing facility's  
5 residents.
- 6           (12) "Certificate of capital authorization" means a certification  
7 from the department for an allocation from the biennial capital  
8 financing authorization for all new or replacement building  
9 construction, or for major renovation projects, receiving a certificate  
10 of need or a certificate of need exemption under chapter 70.38 RCW  
11 after July 1, 2001.
- 12           (13) "Contractor" means a person or entity licensed under chapter  
13 18.51 RCW to operate a medicare and medicaid certified nursing  
14 facility, responsible for operational decisions, and contracting with  
15 the department to provide services to medicaid recipients residing in  
16 the facility.
- 17           (14) "Default case" means no initial assessment has been completed  
18 for a resident and transmitted to the department by the cut-off date,  
19 or an assessment is otherwise past due for the resident, under state  
20 and federal requirements.
- 21           (15) "Department" means the department of social and health  
22 services (DSHS) and its employees.
- 23           (16) "Depreciation" means the systematic distribution of the cost  
24 or other basis of tangible assets, less salvage, over the estimated  
25 useful life of the assets.
- 26           (17) "Direct care" means nursing care and related care provided to  
27 nursing facility residents. Therapy care shall not be considered part  
28 of direct care.
- 29           (18) "Direct care supplies" means medical, pharmaceutical, and  
30 other supplies required for the direct care of a nursing facility's  
31 residents.
- 32           (19) "Entity" means an individual, partnership, corporation,  
33 limited liability company, or any other association of individuals  
34 capable of entering enforceable contracts.
- 35           (20) "Equity" means the net book value of all tangible and  
36 intangible assets less the recorded value of all liabilities, as  
37 recognized and measured in conformity with generally accepted  
38 accounting principles.

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

4 (22) "Facility" or "nursing facility" means a nursing home licensed  
5 in accordance with chapter 18.51 RCW, excepting nursing homes certified  
6 as institutions for mental diseases, or that portion of a multiservice  
7 facility licensed as a nursing home, or that portion of a hospital  
8 licensed in accordance with chapter 70.41 RCW which operates as a  
9 nursing home.

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

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

17 (25) "Generally accepted accounting principles" means accounting  
18 principles approved by the financial accounting standards board (FASB).

19 (26) "Goodwill" means the excess of the price paid for a nursing  
20 facility business over the fair market value of all net identifiable  
21 tangible and intangible assets acquired, as measured in accordance with  
22 generally accepted accounting principles.

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

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

30 (29) "Historical cost" means the actual cost incurred in acquiring  
31 and preparing an asset for use, including feasibility studies,  
32 architect's fees, and engineering studies.

33 (30) "Home and central office costs" means costs that are incurred  
34 in the support and operation of a home and central office. Home and  
35 central office costs include centralized services that are performed in  
36 support of a nursing facility. The department may exclude from this  
37 definition costs that are nonduplicative, documented, ordinary,

1 necessary, and related to the provision of care services to authorized  
2 patients.

3 (31) "Imprest fund" means a fund which is regularly replenished in  
4 exactly the amount expended from it.

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

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

22 (34) "Medical care program" or "medicaid program" means medical  
23 assistance, including nursing care, provided under RCW 74.09.500 or  
24 authorized state medical care services.

25 (35) "Medical care recipient," "medicaid recipient," or "recipient"  
26 means an individual determined eligible by the department for the  
27 services provided under chapter 74.09 RCW.

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

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

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

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

5 (40) "Operating lease" means a lease under which rental or lease  
6 expenses are included in current expenses in accordance with generally  
7 accepted accounting principles.

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

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

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

24 (44) "Professionally designated real estate appraiser" means an  
25 individual who is regularly engaged in the business of providing real  
26 estate valuation services for a fee, and who is deemed qualified by a  
27 nationally recognized real estate appraisal educational organization on  
28 the basis of extensive practical appraisal experience, including the  
29 writing of real estate valuation reports as well as the passing of  
30 written examinations on valuation practice and theory, and who by  
31 virtue of membership in such organization is required to subscribe and  
32 adhere to certain standards of professional practice as such  
33 organization prescribes.

34 (45) "Provider fees" means taxes and assessments levied by any  
35 state or local government, in the form of real estate or property  
36 taxes, and the business and occupation tax levied pursuant to chapter  
37 82.04 RCW.

38 (46) "Qualified therapist" means:

- 1 (a) A mental health professional as defined by chapter 71.05 RCW;
- 2 (b) A mental retardation professional who is a therapist approved  
3 by the department who has had specialized training or one year's  
4 experience in treating or working with the mentally retarded or  
5 developmentally disabled;
- 6 (c) A speech pathologist who is eligible for a certificate of  
7 clinical competence in speech pathology or who has the equivalent  
8 education and clinical experience;
- 9 (d) A physical therapist as defined by chapter 18.74 RCW;
- 10 (e) An occupational therapist who is a graduate of a program in  
11 occupational therapy, or who has the equivalent of such education or  
12 training; and
- 13 (f) A respiratory care practitioner certified under chapter 18.89  
14 RCW.
- 15 ~~((46))~~ (47) "Rate" or "rate allocation" means the medicaid per-  
16 patient-day payment amount for medicaid patients calculated in  
17 accordance with the allocation methodology set forth in part E of this  
18 chapter.
- 19 ~~((47))~~ (48) "Real property," whether leased or owned by the  
20 contractor, means the building, allowable land, land improvements, and  
21 building improvements associated with a nursing facility.
- 22 ~~((48))~~ (49) "Rebased rate" or "cost-rebased rate" means a  
23 facility-specific component rate assigned to a nursing facility for a  
24 particular rate period established on desk-reviewed, adjusted costs  
25 reported for that facility covering at least six months of a prior  
26 calendar year designated as a year to be used for cost-rebasing payment  
27 rate allocations under the provisions of this chapter.
- 28 ~~((49))~~ (50) "Records" means those data supporting all financial  
29 statements and cost reports including, but not limited to, all general  
30 and subsidiary ledgers, books of original entry, and transaction  
31 documentation, however such data are maintained.
- 32 ~~((50))~~ (51) "Related organization" means an entity which is under  
33 common ownership and/or control with, or has control of, or is  
34 controlled by, the contractor.
- 35 (a) "Common ownership" exists when an entity is the beneficial  
36 owner of five percent or more ownership interest in the contractor and  
37 any other entity.

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

5 ~~((+51+))~~ (52) "Related care" means only those services that are  
6 directly related to providing direct care to nursing facility  
7 residents. These services include, but are not limited to, nursing  
8 direction and supervision, medical direction, medical records, pharmacy  
9 services, activities, and social services.

10 ~~((+52+))~~ (53) "Resident assessment instrument," including federally  
11 approved modifications for use in this state, means a federally  
12 mandated, comprehensive nursing facility resident care planning and  
13 assessment tool, consisting of the minimum data set and resident  
14 assessment protocols.

15 ~~((+53+))~~ (54) "Resident assessment protocols" means those  
16 components of the resident assessment instrument that use the minimum  
17 data set to trigger or flag a resident's potential problems and risk  
18 areas.

19 ~~((+54+))~~ (55) "Resource utilization groups" means a case mix  
20 classification system that identifies relative resources needed to care  
21 for an individual nursing facility resident.

22 ~~((+55+))~~ (56) "Restricted fund" means those funds the principal  
23 and/or income of which is limited by agreement with or direction of the  
24 donor to a specific purpose.

25 ~~((+56+))~~ (57) "Secretary" means the secretary of the department of  
26 social and health services.

27 ~~((+57+))~~ (58) "Support services" means food, food preparation,  
28 dietary, housekeeping, and laundry services provided to nursing  
29 facility residents.

30 ~~((+58+))~~ (59) "Therapy care" means those services required by a  
31 nursing facility resident's comprehensive assessment and plan of care,  
32 that are provided by qualified therapists, or support personnel under  
33 their supervision, including related costs as designated by the  
34 department.

35 ~~((+59+))~~ (60) "Title XIX" or "medicaid" means the 1965 amendments  
36 to the social security act, P.L. 89-07, as amended and the medicaid  
37 program administered by the department.

1 ((+60+)) (61) "Urban county" means a county which is located in a  
2 metropolitan statistical area as determined and defined by the United  
3 States office of management and budget or other appropriate agency or  
4 office of the federal government.

5 **Sec. 2.** RCW 74.46.421 and 2001 1st sp.s. c 8 s 4 are each amended  
6 to read as follows:

7 (1) The purpose of part E of this chapter is to determine nursing  
8 facility medicaid payment rates that, in the aggregate for all  
9 participating nursing facilities, are in accordance with the biennial  
10 appropriations act.

11 (2)(a) The department shall use the nursing facility medicaid  
12 payment rate methodologies described in this chapter to determine  
13 initial component rate allocations for each medicaid nursing facility.

14 (b) The initial component rate allocations shall be subject to  
15 adjustment as provided in this section in order to assure that the  
16 statewide average payment rate to nursing facilities is less than or  
17 equal to the statewide average payment rate specified in the biennial  
18 appropriations act.

19 (3) Nothing in this chapter shall be construed as creating a legal  
20 right or entitlement to any payment that (a) has not been adjusted  
21 under this section or (b) would cause the statewide average payment  
22 rate to exceed the statewide average payment rate specified in the  
23 biennial appropriations act.

24 (4)(a) The statewide average payment rate for any state fiscal year  
25 under the nursing facility payment system, weighted by patient days,  
26 shall not exceed the annual statewide weighted average nursing facility  
27 payment rate identified for that fiscal year in the biennial  
28 appropriations act.

29 (b) If the department determines that the weighted average nursing  
30 facility payment rate calculated in accordance with this chapter is  
31 likely to exceed the weighted average nursing facility payment rate  
32 identified in the biennial appropriations act, then the department  
33 shall adjust all nursing facility payment rates proportional to the  
34 amount by which the weighted average rate allocations would otherwise  
35 exceed the budgeted rate amount, except as provided in section 7 of  
36 this act. Any such adjustments shall only be made prospectively, not

1 retrospectively, and shall be applied proportionately to each component  
2 rate allocation for each facility.

3 **Sec. 3.** RCW 74.46.431 and 2005 c 518 s 944 are each amended to  
4 read as follows:

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

12 (2) With the exception of the direct care component, all component  
13 rate allocations for essential community providers as defined in this  
14 chapter shall be based upon a minimum facility occupancy of eighty-five  
15 percent of licensed beds, regardless of how many beds are set up or in  
16 use. For all facilities other than essential community providers,  
17 effective July 1, ((2001)) 2006, component rate allocations in ((direct  
18 care,)) therapy care, support services, and variable return((  
19 operations, property, and financing allowance)) shall continue to be  
20 based upon a minimum facility occupancy of eighty-five percent of  
21 licensed beds. For all facilities other than essential community  
22 providers, effective July 1, ((2002)) 2006, the component rate  
23 allocations in operations, property, and financing allowance shall be  
24 based upon a minimum facility occupancy of ninety percent of licensed  
25 beds, regardless of how many beds are set up or in use. For all  
26 facilities, effective July 1, 2006, the component rate allocation in  
27 direct care shall be based upon actual facility occupancy.

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

34 (4)(a) Direct care component rate allocations shall be established  
35 using adjusted cost report data covering at least six months. Adjusted  
36 ((cost report data from 1996 will be used for October 1, 1998, through  
37 June 30, 2001, direct care component rate allocations; adjusted)) cost

1 report data from 1999 will be used for July 1, 2001, through June 30,  
2 ~~((2005))~~ 2006, direct care component rate allocations. Adjusted cost  
3 report data from ~~((1999))~~ 2004 will continue to be used for July 1,  
4 ~~((2005))~~ 2006, and later direct care component rate allocations.

5 (b) Direct care component rate allocations based on 1996 cost  
6 report data shall be adjusted annually for economic trends and  
7 conditions by a factor or factors defined in the biennial  
8 appropriations act. A different economic trends and conditions  
9 adjustment factor or factors may be defined in the biennial  
10 appropriations act for facilities whose direct care component rate is  
11 set equal to their adjusted June 30, 1998, rate, as provided in RCW  
12 74.46.506(5)(i).

13 (c) Direct care component rate allocations based on 1999 cost  
14 report data shall be adjusted annually for economic trends and  
15 conditions by a factor or factors defined in the biennial  
16 appropriations act. A different economic trends and conditions  
17 adjustment factor or factors may be defined in the biennial  
18 appropriations act for facilities whose direct care component rate is  
19 set equal to their adjusted June 30, 1998, rate, as provided in RCW  
20 74.46.506(5)(i).

21 (5)(a) Therapy care component rate allocations shall be established  
22 using adjusted cost report data covering at least six months. Adjusted  
23 ~~((cost report data from 1996 will be used for October 1, 1998, through  
24 June 30, 2001, therapy care component rate allocations; adjusted))~~ cost  
25 report data from 1999 will be used for July 1, 2001, through June 30,  
26 ~~((2005))~~ 2006, therapy care component rate allocations. Adjusted cost  
27 report data from ~~((1999))~~ 2004 will continue to be used for July 1,  
28 ~~((2005))~~ 2006, and later therapy care component rate allocations.

29 (b) Therapy care component rate allocations shall be adjusted  
30 annually for economic trends and conditions by a factor or factors  
31 defined in the biennial appropriations act.

32 (6)(a) Support services component rate allocations shall be  
33 established using adjusted cost report data covering at least six  
34 months. Adjusted ~~((cost report data from 1996 shall be used for  
35 October 1, 1998, through June 30, 2001, support services component rate  
36 allocations; adjusted))~~ cost report data from 1999 shall be used for  
37 July 1, 2001, through June 30, ~~((2005))~~ 2006, support services

1 component rate allocations. Adjusted cost report data from ((1999))  
2 2004 will continue to be used for July 1, ((2005)) 2006, and later  
3 support services component rate allocations.

4 (b) Support services component rate allocations shall be adjusted  
5 annually for economic trends and conditions by a factor or factors  
6 defined in the biennial appropriations act.

7 (7)(a) Operations component rate allocations shall be established  
8 using adjusted cost report data covering at least six months. Adjusted  
9 cost report data from (~~1996 shall be used for October 1, 1998, through~~  
10 ~~June 30, 2001, operations component rate allocations; adjusted cost~~  
11 ~~report data from~~) 1999 shall be used for July 1, 2001, through June  
12 30, ((2005)) 2006, operations component rate allocations. Adjusted  
13 cost report data from ((1999)) 2004 will continue to be used for July  
14 1, ((2005)) 2006, and later operations component rate allocations.

15 (b) Operations component rate allocations shall be adjusted  
16 annually for economic trends and conditions by a factor or factors  
17 defined in the biennial appropriations act.

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

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

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

31 (11) The department shall establish in rule procedures, principles,  
32 and conditions for determining component rate allocations for  
33 facilities in circumstances not directly addressed by this chapter,  
34 including but not limited to: The need to prorate inflation for  
35 partial-period cost report data, newly constructed facilities, existing  
36 facilities entering the medicaid program for the first time or after a  
37 period of absence from the program, existing facilities with expanded  
38 new bed capacity, existing medicaid facilities following a change of

1 ownership of the nursing facility business, facilities banking beds or  
2 converting beds back into service, facilities temporarily reducing the  
3 number of set-up beds during a remodel, facilities having less than six  
4 months of either resident assessment, cost report data, or both, under  
5 the current contractor prior to rate setting, and other circumstances.

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

11 (13) Effective July 1, 2001, medicaid rates shall continue to be  
12 revised downward in all components, in accordance with department  
13 rules, for facilities converting banked beds to active service under  
14 chapter 70.38 RCW, by using the facility's increased licensed bed  
15 capacity to recalculate minimum occupancy for rate setting. However,  
16 for facilities other than essential community providers which bank beds  
17 under chapter 70.38 RCW, after May 25, 2001, medicaid rates shall be  
18 revised upward, in accordance with department rules, in direct care,  
19 therapy care, support services, and variable return components only, by  
20 using the facility's decreased licensed bed capacity to recalculate  
21 minimum occupancy for rate setting, but no upward revision shall be  
22 made to operations, property, or financing allowance component rates.

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

31 **Sec. 4.** RCW 74.46.506 and 2001 1st sp.s. c 8 s 10 are each amended  
32 to read as follows:

33 (1) The direct care component rate allocation corresponds to the  
34 provision of nursing care for one resident of a nursing facility for  
35 one day, including direct care supplies. Therapy services and  
36 supplies, which correspond to the therapy care component rate, shall be

1 excluded. The direct care component rate includes elements of case mix  
2 determined consistent with the principles of this section and other  
3 applicable provisions of this chapter.

4 (2) Beginning October 1, 1998, the department shall determine and  
5 update quarterly for each nursing facility serving medicaid residents  
6 a facility-specific per-resident day direct care component rate  
7 allocation, to be effective on the first day of each calendar quarter.  
8 In determining direct care component rates the department shall  
9 utilize, as specified in this section, minimum data set resident  
10 assessment data for each resident of the facility, as transmitted to,  
11 and if necessary corrected by, the department in the resident  
12 assessment instrument format approved by federal authorities for use in  
13 this state.

14 (3) The department may question the accuracy of assessment data for  
15 any resident and utilize corrected or substitute information, however  
16 derived, in determining direct care component rates. The department is  
17 authorized to impose civil fines and to take adverse rate actions  
18 against a contractor, as specified by the department in rule, in order  
19 to obtain compliance with resident assessment and data transmission  
20 requirements and to ensure accuracy.

21 (4) Cost report data used in setting direct care component rate  
22 allocations shall be 1996 (~~and~~), 1999, and 2004 for rate periods as  
23 specified in RCW 74.46.431(4)(a).

24 (5) Beginning October 1, 1998, the department shall rebase each  
25 nursing facility's direct care component rate allocation as described  
26 in RCW 74.46.431, adjust its direct care component rate allocation for  
27 economic trends and conditions as described in RCW 74.46.431, and  
28 update its medicaid average case mix index, consistent with the  
29 following:

30 (a) Reduce total direct care costs reported by each nursing  
31 facility for the applicable cost report period specified in RCW  
32 74.46.431(4)(a) to reflect any department adjustments, and to eliminate  
33 reported resident therapy costs and adjustments, in order to derive the  
34 facility's total allowable direct care cost;

35 (b) Divide each facility's total allowable direct care cost by its  
36 adjusted resident days for the same report period(~~(, increased if~~  
37 ~~necessary to a minimum occupancy of eighty five percent; that is, the~~

1 ~~greater of actual or imputed occupancy at eighty five percent of~~  
2 ~~licensed beds,~~) to derive the facility's allowable direct care cost  
3 per resident day;

4 (c) Adjust the facility's per resident day direct care cost by the  
5 applicable factor specified in RCW 74.46.431(4) (b) and (c) to derive  
6 its adjusted allowable direct care cost per resident day;

7 (d) Divide each facility's adjusted allowable direct care cost per  
8 resident day by the facility average case mix index for the applicable  
9 quarters specified by RCW 74.46.501(7)(b) to derive the facility's  
10 allowable direct care cost per case mix unit;

11 (e) Effective for July 1, 2001, rate setting, divide nursing  
12 facilities into at least two and, if applicable, three peer groups:  
13 Those located in nonurban counties; those located in high labor-cost  
14 counties, if any; and those located in other urban counties;

15 (f) Array separately the allowable direct care cost per case mix  
16 unit for all facilities in nonurban counties; for all facilities in  
17 high labor-cost counties, if applicable; and for all facilities in  
18 other urban counties, and determine the median allowable direct care  
19 cost per case mix unit for each peer group;

20 (g) Except as provided in (i) of this subsection, from October 1,  
21 1998, through June 30, 2000, determine each facility's quarterly direct  
22 care component rate as follows:

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

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

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

7 (h) Except as provided in (i) of this subsection, from July 1,  
8 2000, forward, and for all future rate setting, determine each  
9 facility's quarterly direct care component rate as follows:

10 ~~(i) ((Any facility whose allowable cost per case mix unit is less  
11 than ninety percent of the facility's peer group median established  
12 under (f) of this subsection shall be assigned a cost per case mix unit  
13 equal to ninety percent of the facility's peer group median, and shall  
14 have a direct care component rate allocation equal to the facility's  
15 assigned cost per case mix unit multiplied by that facility's medicaid  
16 average case mix index from the applicable quarter specified in RCW  
17 74.46.501(7)(c);~~

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

26 ~~((iii))~~ (ii) Any facility whose allowable cost per case mix unit  
27 is ~~((between ninety and))~~ under one hundred ten percent of the peer  
28 group median established under (f) of this subsection shall have a  
29 direct care component rate allocation equal to the facility's allowable  
30 cost per case mix unit multiplied by that facility's medicaid average  
31 case mix index from the applicable quarter specified in RCW  
32 74.46.501(7)(c);

33 (i)(i) Between October 1, 1998, and June 30, 2000, the department  
34 shall compare each facility's direct care component rate allocation  
35 calculated under (g) of this subsection with the facility's nursing  
36 services component rate in effect on September 30, 1998, less therapy  
37 costs, plus any exceptional care offsets as reported on the cost

1 report, adjusted for economic trends and conditions as provided in RCW  
2 74.46.431. A facility shall receive the higher of the two rates.

3 (ii) Between July 1, 2000, and June 30, 2002, the department shall  
4 compare each facility's direct care component rate allocation  
5 calculated under (h) of this subsection with the facility's direct care  
6 component rate in effect on June 30, 2000. A facility shall receive  
7 the higher of the two rates. Between July 1, 2001, and June 30, 2002,  
8 if during any quarter a facility whose rate paid under (h) of this  
9 subsection is greater than either the direct care rate in effect on  
10 June 30, 2000, or than that facility's allowable direct care cost per  
11 case mix unit calculated in (d) of this subsection multiplied by that  
12 facility's medicaid average case mix index from the applicable quarter  
13 specified in RCW 74.46.501(7)(c), the facility shall be paid in that  
14 and each subsequent quarter pursuant to (h) of this subsection and  
15 shall not be entitled to the greater of the two rates.

16 (iii) Effective July 1, 2002, all direct care component rate  
17 allocations shall be as determined under (h) of this subsection.

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

21 (7) Payments resulting from increases in direct care component  
22 rates, granted under authority of RCW 74.46.508(1) for a facility's  
23 exceptional care residents, shall be offset against the facility's  
24 examined, allowable direct care costs, for each report year or partial  
25 period such increases are paid. Such reductions in allowable direct  
26 care costs shall be for rate setting, settlement, and other purposes  
27 deemed appropriate by the department.

28 **Sec. 5.** RCW 74.46.511 and 2001 1st sp.s. c 8 s 11 are each amended  
29 to read as follows:

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

1 on adjusted therapy costs and days from calendar year 1999. The  
2 therapy component rate allocation for July 1, 2006, and later shall be  
3 based on adjusted therapy costs and days from calendar year 2004. The  
4 therapy care component rate shall be adjusted for economic trends and  
5 conditions as specified in RCW 74.46.431(5)(b), and shall be determined  
6 in accordance with this section.

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

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

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

16 (c) Therapy consulting expenses for all residents.

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

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

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

24 (b) Those located within nonurban counties.

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

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

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

1 (b) The medicaid allowable one-on-one therapy expense shall be  
2 calculated taking the allowable total therapy cost for each therapy  
3 type times the medicaid percent of total therapy charges for each  
4 therapy type;

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

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

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

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

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

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

32 **Sec. 6.** RCW 74.46.521 and 2001 1st sp.s. c 8 s 13 are each amended  
33 to read as follows:

34 (1) The operations component rate allocation corresponds to the  
35 general operation of a nursing facility for one resident for one day,  
36 including but not limited to management, administration, utilities,  
37 office supplies, accounting and bookkeeping, minor building

1 maintenance, minor equipment repairs and replacements, and other  
2 supplies and services, exclusive of direct care, therapy care, support  
3 services, property, financing allowance, and variable return.

4 (2) Beginning October 1, 1998, the department shall determine each  
5 medicaid nursing facility's operations component rate allocation using  
6 cost report data specified by RCW 74.46.431(7)(a). Effective July 1,  
7 2002, operations component rates for all facilities except essential  
8 community providers shall be based upon a minimum occupancy of ninety  
9 percent of licensed beds, and no operations component rate shall be  
10 revised in response to beds banked on or after May 25, 2001, under  
11 chapter 70.38 RCW.

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

14 (a)(i) Array facilities' adjusted general operations costs per  
15 adjusted resident day for each facility from facilities' cost reports  
16 from the applicable report year, for facilities located within urban  
17 counties and for those located within nonurban counties and determine  
18 the median adjusted cost for each peer group.

19 (ii) Beginning July 1, 2006, the department shall subtract the cost  
20 of provider fees, as defined in RCW 74.46.020, from the operations  
21 costs prior to determining the adjusted operations costs per resident  
22 day;

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

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

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

31 (c) Beginning July 1, 2006, the department shall grant a property  
32 and business tax add-on rate to the operations component rate:

33 (i) The property and business tax add-on rate shall be determined  
34 by dividing the sum of provider fees, as defined in RCW 74.46.020, by  
35 each facility's actual total resident days. Minimum occupancy levels  
36 shall not be used in calculating the property and business tax add-on  
37 rate; and

1        (ii) The property and business tax add-on rate shall be added to  
2 the operations component rate as determined under (b) of this  
3 subsection; and

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

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

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

11        (1) The department shall include a "hold harmless" provision after  
12 rebasing to 2004 costs for the July 1, 2006, through June 30, 2007,  
13 rate-setting period.

14        (2) The department shall determine each facility's expected rate  
15 for July 1, 2006, adjusted for economic terms and conditions according  
16 to the biennial appropriations act, according to the methodology and  
17 budget provisions in place prior to the effective date of this act.

18        (3) For the July 1, 2006, through June 30, 2007, rate-setting  
19 period, the department shall set each facility's rate at the higher of:

20        (a) The rate determined in accordance with the provisions of RCW  
21 74.46.421 through 74.46.535; or

22        (b) The rate determined under subsection (2) of this section.

23        (4)(a) If the department determines that the weighted average  
24 nursing facility payment rate calculated in accordance with this  
25 chapter for the July 1, 2006, through June 30, 2007, rate-setting  
26 period is likely to exceed the weighted average nursing facility  
27 payment rate identified in the biennial appropriations act, then the  
28 department shall:

29        (i) Determine, for each facility, the increase in its rate  
30 calculated under subsection (3)(a) of this section over its rate  
31 calculated under subsection (2) of this section. For facilities whose  
32 rate under subsection (2) of this section is greater than its rate  
33 under subsection (3)(a) of this section, the increase shall be zero;

34        (ii) Reduce the amount of the increase determined under (a)(i) of  
35 this subsection by a proportional amount in each cost center across  
36 facilities, except for those facilities where the increase is zero,

1 until the weighted average nursing facility payment rate identified in  
2 the biennial appropriations act is reached.

3 (b) In applying the methodology in (a) of this subsection, the  
4 department shall not reduce any facility's rate below the rate  
5 determined under subsection (2) of this section.

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