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HOUSE BILL 2898

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State of Washington

61st Legislature

2010 Regular Session

By Representatives Morrell, Pettigrew, Cody, Bailey, Kenney, and Johnson; by request of Department of Social and Health Services

Read first time 01/18/10. Referred to Committee on Health & Human Services Appropriations.

1 AN ACT Relating to maintaining the current medicaid nursing  
2 facility payment methodology through simplification of the nursing  
3 facility medicaid payment system statute; amending RCW 74.46.010,  
4 74.46.020, 74.46.431, 74.46.433, 74.46.435, 74.46.437, 74.46.439,  
5 74.46.475, 74.46.496, 74.46.501, 74.46.506, 74.46.508, 74.46.511,  
6 74.46.515, 74.46.521, 74.46.835, and 74.46.800; creating a new section;  
7 and repealing RCW 74.46.030, 74.46.040, 74.46.050, 74.46.060,  
8 74.46.080, 74.46.090, 74.46.100, 74.46.155, 74.46.165, 74.46.190,  
9 74.46.200, 74.46.220, 74.46.230, 74.46.240, 74.46.250, 74.46.270,  
10 74.46.280, 74.46.290, 74.46.300, 74.46.310, 74.46.320, 74.46.330,  
11 74.46.340, 74.46.350, 74.46.360, 74.46.370, 74.46.380, 74.46.390,  
12 74.46.410, 74.46.445, 74.46.533, 74.46.600, 74.46.610, 74.46.620,  
13 74.46.625, 74.46.630, 74.46.640, 74.46.650, 74.46.660, 74.46.680,  
14 74.46.690, 74.46.700, 74.46.711, 74.46.770, 74.46.780, 74.46.790,  
15 74.46.820, 74.46.900, 74.46.901, 74.46.902, 74.46.905, and 74.46.906.

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

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

1 This chapter may be known and cited as the "nursing facility  
2 medicaid payment system."

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

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

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

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

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

24 ~~((3))~~ (2) "Arm's-length transaction" means a transaction  
25 resulting from good-faith bargaining between a buyer and seller who are  
26 not related organizations and have adverse positions in the market  
27 place. Sales or exchanges of nursing home facilities among two or more  
28 parties in which all parties subsequently continue to own one or more  
29 of the facilities involved in the transactions shall not be considered  
30 as arm's-length transactions for purposes of this chapter. Sale of a  
31 nursing home facility which is subsequently leased back to the seller  
32 within five years of the date of sale shall not be considered as an  
33 arm's-length transaction for purposes of this chapter.

34 ~~((4))~~ (3) "Assets" means economic resources of the contractor,  
35 recognized and measured in conformity with generally accepted  
36 accounting principles.

1           ~~((+5))~~ (4) "Audit" or "department audit" means an examination of  
2 the records of a nursing facility participating in the medicaid payment  
3 system, including but not limited to: The contractor's financial and  
4 statistical records, cost reports and all supporting documentation and  
5 schedules, receivables, and resident trust funds, to be performed as  
6 deemed necessary by the department and according to department rule.

7           ~~((+6) "Bad debts" means amounts considered to be uncollectible from  
8 accounts and notes receivable.~~

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

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

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

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

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

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

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

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

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

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

32          ~~except that, any person who acquires an ownership interest or power  
33 specified in (c)(i), (ii), or (iii) of this subsection with the purpose  
34 or effect of changing or influencing the control of the contractor, or  
35 in connection with or as a participant in any transaction having such  
36 purpose or effect, immediately upon such acquisition shall be deemed to  
37 be the beneficial owner of the ownership interest which may be acquired  
38 through the exercise or conversion of such ownership interest or power;~~

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

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

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

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

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

21       ~~(+8))~~ (5) "Capitalization" means the recording of an expenditure as  
22 an asset.

23       ~~((+9))~~ (6) "Case mix" means a measure of the intensity of care and  
24 services needed by the residents of a nursing facility or a group of  
25 residents in the facility.

26       ~~((+10))~~ (7) "Case mix index" means a number representing the  
27 average case mix of a nursing facility.

28       ~~((+11))~~ (8) "Case mix weight" means a numeric score that  
29 identifies the relative resources used by a particular group of a  
30 nursing facility's residents.

31       ~~((+12))~~ (9) "Certificate of capital authorization" means a  
32 certification from the department for an allocation from the biennial  
33 capital financing authorization for all new or replacement building  
34 construction, or for major renovation projects, receiving a certificate  
35 of need or a certificate of need exemption under chapter 70.38 RCW  
36 after July 1, 2001.

37       ~~((+13))~~ (10) "Contractor" means a person or entity licensed under  
38 chapter 18.51 RCW to operate a medicare and medicaid certified nursing

1 facility, responsible for operational decisions, and contracting with  
2 the department to provide services to medicaid recipients residing in  
3 the facility.

4 ~~((+14))~~ (11) "Default case" means no initial assessment has been  
5 completed for a resident and transmitted to the department by the  
6 cut-off date, or an assessment is otherwise past due for the resident,  
7 under state and federal requirements.

8 ~~((+15))~~ (12) "Department" means the department of social and  
9 health services (DSHS) and its employees.

10 ~~((+16))~~ (13) "Depreciation" means the systematic distribution of  
11 the cost or other basis of tangible assets, less salvage, over the  
12 estimated useful life of the assets.

13 ~~((+17))~~ (14) "Direct care" means nursing care and related care  
14 provided to nursing facility residents. Therapy care shall not be  
15 considered part of direct care.

16 ~~((+18))~~ (15) "Direct care supplies" means medical, pharmaceutical,  
17 and other supplies required for the direct care of a nursing facility's  
18 residents.

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

22 ~~((+20))~~ (17) "Equity" means the net book value of all tangible and  
23 intangible assets less the recorded value of all liabilities, as  
24 recognized and measured in conformity with generally accepted  
25 accounting principles.

26 ~~((+21))~~ (18) "Essential community provider" means a facility which  
27 is the only nursing facility within a commuting distance radius of at  
28 least forty minutes duration, traveling by automobile.

29 ~~((+22))~~ (19) "Facility" or "nursing facility" means a nursing home  
30 licensed in accordance with chapter 18.51 RCW, excepting nursing homes  
31 certified as institutions for mental diseases, or that portion of a  
32 multiservice facility licensed as a nursing home, or that portion of a  
33 hospital licensed in accordance with chapter 70.41 RCW which operates  
34 as a nursing home.

35 ~~((+23))~~ (20) "Fair market value" means the replacement cost of an  
36 asset less observed physical depreciation on the date for which the  
37 market value is being determined.

1           ~~((+24))~~ (21) "Financial statements" means statements prepared and  
2 presented in conformity with generally accepted accounting principles  
3 including, but not limited to, balance sheet, statement of operations,  
4 statement of changes in financial position, and related notes.

5           ~~((+25))~~ (22) "Generally accepted accounting principles" means  
6 accounting principles approved by the financial accounting standards  
7 board (FASB) or its successor.

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

12           ~~(+27))~~ (23) "Groupers" means a computer software product that groups  
13 individual nursing facility residents into case mix classification  
14 groups based on specific resident assessment data and computer logic.

15           ~~((+28))~~ (24) "High labor-cost county" means an urban county in  
16 which the median allowable facility cost per case mix unit is more than  
17 ten percent higher than the median allowable facility cost per case mix  
18 unit among all other urban counties, excluding that county.

19           ~~((+29))~~ (25) "Historical cost" means the actual cost incurred in  
20 acquiring and preparing an asset for use, including feasibility  
21 studies, architect's fees, and engineering studies.

22           ~~((+30))~~ (26) "Home and central office costs" means costs that are  
23 incurred in the support and operation of a home and central office.  
24 Home and central office costs include centralized services that are  
25 performed in support of a nursing facility. The department may exclude  
26 from this definition costs that are nonduplicative, documented,  
27 ordinary, necessary, and related to the provision of care services to  
28 authorized patients.

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

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

34           ~~(+33))~~ (27) "Lease agreement" means a contract between two parties  
35 for the possession and use of real or personal property or assets for  
36 a specified period of time in exchange for specified periodic payments.  
37 Elimination (due to any cause other than death or divorce) or addition  
38 of any party to the contract, expiration, or modification of any lease

1 term in effect on January 1, 1980, or termination of the lease by  
2 either party by any means shall constitute a termination of the lease  
3 agreement. An extension or renewal of a lease agreement, whether or  
4 not pursuant to a renewal provision in the lease agreement, shall be  
5 considered a new lease agreement. A strictly formal change in the  
6 lease agreement which modifies the method, frequency, or manner in  
7 which the lease payments are made, but does not increase the total  
8 lease payment obligation of the lessee, shall not be considered  
9 modification of a lease term.

10 ~~((+34+))~~ (28) "Medical care program" or "medicaid program" means  
11 medical assistance, including nursing care, provided under RCW  
12 74.09.500 or authorized state medical care services.

13 ~~((+35+))~~ (29) "Medical care recipient," "medicaid recipient," or  
14 "recipient" means an individual determined eligible by the department  
15 for the services provided under chapter 74.09 RCW.

16 ~~((+36+))~~ (30) "Minimum data set" means the overall data component  
17 of the resident assessment instrument, indicating the strengths, needs,  
18 and preferences of an individual nursing facility resident.

19 ~~((+37+))~~ (31) "Net book value" means the historical cost of an  
20 asset less accumulated depreciation.

21 ~~((+38+))~~ (32) "Net invested funds" means the net book value of  
22 tangible fixed assets employed by a contractor to provide services  
23 under the medical care program, including land, buildings, and  
24 equipment as recognized and measured in conformity with generally  
25 accepted accounting principles.

26 ~~((+39+))~~ (33) "Nonurban county" means a county which is not located  
27 in a metropolitan statistical area as determined and defined by the  
28 United States office of management and budget or other appropriate  
29 agency or office of the federal government.

30 ~~((+40+))~~ ~~"Operating lease" means a lease under which rental or lease~~  
31 ~~expenses are included in current expenses in accordance with generally~~  
32 ~~accepted accounting principles.~~

33 ~~(+41+))~~ (34) "Owner" means a sole proprietor, general or limited  
34 partners, members of a limited liability company, and beneficial  
35 interest holders of five percent or more of a corporation's outstanding  
36 stock.

37 ~~((+42+))~~ ~~"Ownership interest" means all interests beneficially owned~~

1 ~~by a person, calculated in the aggregate, regardless of the form which~~  
2 ~~such beneficial ownership takes.~~

3 ~~(43))~~ (35) "Patient day" or "resident day" means a calendar day of  
4 care provided to a nursing facility resident, regardless of payment  
5 source, which will include the day of admission and exclude the day of  
6 discharge; except that, when admission and discharge occur on the same  
7 day, one day of care shall be deemed to exist. A "medicaid day" or  
8 "recipient day" means a calendar day of care provided to a medicaid  
9 recipient determined eligible by the department for services provided  
10 under chapter 74.09 RCW, subject to the same conditions regarding  
11 admission and discharge applicable to a patient day or resident day of  
12 care.

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

23 ~~(45))~~ (36) "Qualified therapist" means:

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

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

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

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

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

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

1           ~~((46))~~ (37) "Rate" or "rate allocation" means the medicaid per-  
2 patient-day payment amount for medicaid patients calculated in  
3 accordance with the allocation methodology set forth in part E of this  
4 chapter.

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

8           ~~(48))~~ (38) "Rebased rate" or "cost-rebased rate" means a facility-  
9 specific component rate assigned to a nursing facility for a particular  
10 rate period established on desk-reviewed, adjusted costs reported for  
11 that facility covering at least six months of a prior calendar year  
12 designated as a year to be used for cost-rebasing payment rate  
13 allocations under the provisions of this chapter.

14           ~~((49))~~ (39) "Records" means those data supporting all financial  
15 statements and cost reports including, but not limited to, all general  
16 and subsidiary ledgers, books of original entry, and transaction  
17 documentation, however such data are maintained.

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

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

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

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

33           ~~(52))~~ (40) "Resident assessment instrument," including federally  
34 approved modifications for use in this state, means a federally  
35 mandated, comprehensive nursing facility resident care planning and  
36 assessment tool, consisting of the minimum data set and resident  
37 assessment protocols.

1           ~~((+53+))~~ (41) "Resident assessment protocols" means those  
2 components of the resident assessment instrument that use the minimum  
3 data set to trigger or flag a resident's potential problems and risk  
4 areas.

5           ~~((+54+))~~ (42) "Resource utilization groups" means a case mix  
6 classification system that identifies relative resources needed to care  
7 for an individual nursing facility resident.

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

11           ~~(+56+))~~ (43) "Secretary" means the secretary of the department of  
12 social and health services.

13           ~~((+57+))~~ (44) "Support services" means food, food preparation,  
14 dietary, housekeeping, and laundry services provided to nursing  
15 facility residents.

16           ~~((+58+))~~ (45) "Therapy care" means those services required by a  
17 nursing facility resident's comprehensive assessment and plan of care,  
18 that are provided by qualified therapists, or support personnel under  
19 their supervision, including related costs as designated by the  
20 department.

21           ~~((+59+))~~ (46) "Title XIX" or "medicaid" means the 1965 amendments  
22 to the social security act, P.L. 89-07, as amended and the medicaid  
23 program administered by the department.

24           ~~((+60+))~~ (47) "Urban county" means a county which is located in a  
25 metropolitan statistical area as determined and defined by the United  
26 States office of management and budget or other appropriate agency or  
27 office of the federal government.

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

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

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

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

37           ~~The definition of "vital local provider" shall expire, and have no~~

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

4 NEW SECTION. **Sec. 3.** The department shall establish, by rule, the  
5 procedures, principles, and conditions for the nursing facility  
6 medicaid payment system addressed by the following principles:

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

14 (2) The department shall examine all cost reports to determine  
15 whether the information is correct, complete, and reported in  
16 compliance with chapter 74.46 RCW, department rules and instructions,  
17 and generally accepted accounting principles.

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

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

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

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

1 (7) The department shall define and identify allowable and  
2 unallowable costs.

3 (8) A contractor shall bill the department for care provided to  
4 medicaid recipients, and the department shall pay a contractor for  
5 service rendered under the facility contract and appropriately billed.  
6 Billing and payment procedures shall be specified by rule.

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

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

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

17 (12) The department shall have authority to adopt, amend, and  
18 rescind such administrative rules and definitions as it deems necessary  
19 to carry out the policies and purposes of chapter 74.46 RCW.

20 **Sec. 4.** RCW 74.46.431 and 2009 c 570 s 1 are each amended to read  
21 as follows:

22 (1) (~~Effective July 1, 1999,~~) Nursing facility medicaid payment  
23 rate allocations shall be facility-specific and shall have seven  
24 components: Direct care, therapy care, support services, operations,  
25 property, financing allowance, and variable return. The department  
26 shall establish and adjust each of these components, as provided in  
27 this section and elsewhere in this chapter, for each medicaid nursing  
28 facility in this state.

29 (2) Component rate allocations in therapy care, support services,  
30 variable return, operations, property, and financing allowance for  
31 essential community providers as defined in this chapter shall be based  
32 upon a minimum facility occupancy of eighty-five percent of licensed  
33 beds, regardless of how many beds are set up or in use. For all  
34 facilities other than essential community providers, (~~effective July~~  
35 ~~1, 2001,~~) the component rate allocations in (~~direct care,~~) therapy  
36 care, support services, and variable return shall be based upon a  
37 minimum facility occupancy of eighty-five percent of licensed beds.

1 For all facilities other than essential community providers,  
2 (~~effective July 1, 2002,~~) the component rate allocations in  
3 operations, property, and financing allowance shall be based upon a  
4 minimum facility occupancy of ninety percent of licensed beds,  
5 regardless of how many beds are set up or in use. For all facilities,  
6 (~~effective July 1, 2006,~~) the component rate allocation in direct  
7 care shall be based upon actual facility occupancy. The median cost  
8 limits used to set component rate allocations shall be based on the  
9 applicable minimum occupancy percentage. In determining each  
10 facility's therapy care component rate allocation under RCW 74.46.511,  
11 the department shall apply the applicable minimum facility occupancy  
12 adjustment before creating the array of facilities' adjusted therapy  
13 costs per adjusted resident day. In determining each facility's  
14 support services component rate allocation under RCW 74.46.515(3), the  
15 department shall apply the applicable minimum facility occupancy  
16 adjustment before creating the array of facilities' adjusted support  
17 services costs per adjusted resident day. In determining each  
18 facility's operations component rate allocation under RCW 74.46.521(3),  
19 the department shall apply the minimum facility occupancy adjustment  
20 before creating the array of facilities' adjusted general operations  
21 costs per adjusted resident day.

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

28 (4)(a) Direct care component rate allocations shall be established  
29 using adjusted cost report data covering at least six months.  
30 (~~Adjusted cost report data from 1996 will be used for October 1, 1998,~~  
31 ~~through June 30, 2001, direct care component rate allocations; adjusted~~  
32 ~~cost report data from 1999 will be used for July 1, 2001, through June~~  
33 ~~30, 2006, direct care component rate allocations. Adjusted cost report~~  
34 ~~data from 2003 will be used for July 1, 2006, through June 30, 2007,~~  
35 ~~direct care component rate allocations. Adjusted cost report data from~~  
36 ~~2005 will be used for July 1, 2007, through June 30, 2009, direct care~~  
37 ~~component rate allocations.)) Effective July 1, 2009, the direct care  
38 component rate allocation shall be rebased biennially, and thereafter~~

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

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 ~~(d) Direct care component rate allocations based on 2003 cost  
22 report data shall be adjusted annually for economic trends and  
23 conditions by a factor or factors defined in the biennial  
24 appropriations act. A different economic trends and conditions  
25 adjustment factor or factors may be defined in the biennial  
26 appropriations act for facilities whose direct care component rate is  
27 set equal to their adjusted June 30, 2006, rate, as provided in RCW  
28 74.46.506(5)(i)).~~

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

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

5 (5)(a) Therapy care component rate allocations shall be established  
6 using adjusted cost report data covering at least six months.  
7 (~~Adjusted cost report data from 1996 will be used for October 1, 1998,~~  
8 ~~through June 30, 2001, therapy care component rate allocations;~~  
9 ~~adjusted cost report data from 1999 will be used for July 1, 2001,~~  
10 ~~through June 30, 2005, therapy care component rate allocations.~~  
11 ~~Adjusted cost report data from 1999 will continue to be used for July~~  
12 ~~1, 2005, through June 30, 2007, therapy care component rate~~  
13 ~~allocations. Adjusted cost report data from 2005 will be used for July~~  
14 ~~1, 2007, through June 30, 2009, therapy care component rate~~  
15 ~~allocations.))~~ Effective July 1, 2009, and thereafter for each  
16 odd-numbered year beginning July 1st, the therapy care component rate  
17 allocation shall be cost rebased biennially, using the adjusted cost  
18 report data for the calendar year two years immediately preceding the  
19 rate rebase period, so that adjusted cost report data for calendar year  
20 2007 is used for July 1, 2009, through June 30, 2011, and so forth.

21 (b) Therapy care component rate allocations established in  
22 accordance with this chapter shall be adjusted annually for economic  
23 trends and conditions by a factor or factors defined in the biennial  
24 appropriations act. The economic trends and conditions factor or  
25 factors defined in the biennial appropriations act shall not be  
26 compounded with the economic trends and conditions factor or factors  
27 defined in any other biennial appropriations acts before applying it to  
28 the therapy care component rate allocation established in accordance  
29 with this chapter. When no economic trends and conditions factor or  
30 factors for either fiscal year are defined in a biennial appropriations  
31 act, no economic trends and conditions factor or factors defined in any  
32 earlier biennial appropriations act shall be applied solely or  
33 compounded to the therapy care component rate allocation established in  
34 accordance with this chapter.

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

1 ~~allocations; adjusted cost report data from 1999 shall be used for July~~  
2 ~~1, 2001, through June 30, 2005, support services component rate~~  
3 ~~allocations. Adjusted cost report data from 1999 will continue to be~~  
4 ~~used for July 1, 2005, through June 30, 2007, support services~~  
5 ~~component rate allocations. Adjusted cost report data from 2005 will~~  
6 ~~be used for July 1, 2007, through June 30, 2009, support services~~  
7 ~~component rate allocations.))~~ Effective July 1, 2009, and thereafter  
8 for each odd-numbered year beginning July 1st, the support services  
9 component rate allocation shall be cost rebased biennially, using the  
10 adjusted cost report data for the calendar year two years immediately  
11 preceding the rate rebase period, so that adjusted cost report data for  
12 calendar year 2007 is used for July 1, 2009, through June 30, 2011, and  
13 so forth.

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

28 (7)(a) Operations component rate allocations shall be established  
29 using adjusted cost report data covering at least six months.  
30 (~~Adjusted cost report data from 1996 shall be used for October 1,~~  
31 ~~1998, through June 30, 2001, operations component rate allocations;~~  
32 ~~adjusted cost report data from 1999 shall be used for July 1, 2001,~~  
33 ~~through June 30, 2006, operations component rate allocations. Adjusted~~  
34 ~~cost report data from 2003 will be used for July 1, 2006, through June~~  
35 ~~30, 2007, operations component rate allocations. Adjusted cost report~~  
36 ~~data from 2005 will be used for July 1, 2007, through June 30, 2009,~~  
37 ~~operations component rate allocations.))~~ Effective July 1, 2009, and  
38 thereafter for each odd-numbered year beginning July 1st, the

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

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

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

30 ~~(9))~~ (8) Total payment rates under the nursing facility medicaid  
31 payment system shall not exceed facility rates charged to the general  
32 public for comparable services.

33 ~~((10) Medicaid contractors shall pay to all facility staff a~~  
34 ~~minimum wage of the greater of the state minimum wage or the federal~~  
35 ~~minimum wage.~~

36 ~~(11))~~ (9) The department shall establish in rule procedures,  
37 principles, and conditions for determining component rate allocations  
38 for facilities in circumstances not directly addressed by this chapter,

1 including but not limited to: ~~((The need to prorate))~~ Inflation  
2 adjustments for partial-period cost report data, newly constructed  
3 facilities, existing facilities entering the medicaid program for the  
4 first time or after a period of absence from the program, existing  
5 facilities with expanded new bed capacity, existing medicaid facilities  
6 following a change of ownership of the nursing facility business,  
7 facilities banking beds or converting beds back into service,  
8 facilities temporarily reducing the number of set-up beds during a  
9 remodel, facilities having less than six months of either resident  
10 assessment, cost report data, or both, under the current contractor  
11 prior to rate setting, and other circumstances.

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

17 ~~((+13))~~ (11) Effective July 1, 2001, medicaid rates shall continue  
18 to be revised downward in all components, in accordance with department  
19 rules, for facilities converting banked beds to active service under  
20 chapter 70.38 RCW, by using the facility's increased licensed bed  
21 capacity to recalculate minimum occupancy for rate setting. However,  
22 for facilities other than essential community providers which bank beds  
23 under chapter 70.38 RCW, after May 25, 2001, medicaid rates shall be  
24 revised upward, in accordance with department rules, in direct care,  
25 therapy care, support services, and variable return components only, by  
26 using the facility's decreased licensed bed capacity to recalculate  
27 minimum occupancy for rate setting, but no upward revision shall be  
28 made to operations, property, or financing allowance component rates.  
29 Effective July 1, 2006, the direct care component rate allocation shall  
30 be ~~((adjusted, without using the minimum occupancy assumption, for~~  
31 ~~facilities that convert banked beds to active service, under chapter~~  
32 ~~70.38 RCW, beginning on July 1, 2006. Effective July 1, 2007,~~  
33 ~~component rate allocations for direct care shall be))~~ based on actual  
34 patient days regardless of whether a facility has converted banked beds  
35 to active service.

36 ~~((+14))~~ (12) Facilities obtaining a certificate of need or a  
37 certificate of need exemption under chapter 70.38 RCW after June 30,  
38 2001, must have a certificate of capital authorization in order for (a)

1 the depreciation resulting from the capitalized addition to be included  
2 in calculation of the facility's property component rate allocation;  
3 and (b) the net invested funds associated with the capitalized addition  
4 to be included in calculation of the facility's financing allowance  
5 rate allocation.

6 **Sec. 5.** RCW 74.46.433 and 2006 c 258 s 3 are each amended to read  
7 as follows:

8 (1) The department shall establish for each medicaid nursing  
9 facility a variable return component rate allocation. In determining  
10 the variable return allowance:

11 (a) Except as provided in (~~(e)~~) (d) of this subsection, the  
12 variable return array and percentage shall be assigned whenever  
13 rebasing of noncapital rate allocations is scheduled under RCW  
14 74.46.431 (4), (5), (6), and (7).

15 (b) To calculate the array of facilities (~~for the July 1, 2001,~~  
16 ~~rate setting~~), the department, without using peer groups, shall first  
17 rank all facilities in numerical order from highest to lowest according  
18 to each facility's examined and documented, but unlidged, combined  
19 direct care, therapy care, support services, and operations per  
20 resident day cost (~~from the 1999 cost report period~~) from the  
21 applicable cost report period specified in RCW 74.46.431(4)(a).  
22 However, before being combined with other per resident day costs and  
23 ranked, a facility's direct care cost per resident day shall be  
24 adjusted to reflect its facility average case mix index, to be averaged  
25 from the four calendar quarters of (~~1999~~) the cost report period  
26 identified in RCW 74.46.431(4)(a), weighted by the facility's resident  
27 days from each quarter, under RCW 74.46.501(7)(b)(ii). The array shall  
28 then be divided into four quartiles, each containing, as nearly as  
29 possible, an equal number of facilities, and four percent shall be  
30 assigned to facilities in the lowest quartile, three percent to  
31 facilities in the next lowest quartile, two percent to facilities in  
32 the next highest quartile, and one percent to facilities in the highest  
33 quartile.

34 (c) The department shall(~~, subject to (d) of this subsection,~~)  
35 compute the variable return allowance by multiplying a facility's  
36 assigned percentage by the sum of the facility's direct care, therapy

1 care, support services, and operations component rates determined in  
2 accordance with this chapter and rules adopted by the department.

3 ~~(d) ((Effective July 1, 2001, if a facility's examined and  
4 documented direct care cost per resident day for the preceding report  
5 year is lower than its average direct care component rate weighted by  
6 medicaid resident days for the same year, the facility's direct care  
7 cost shall be substituted for its July 1, 2001, direct care component  
8 rate, and its variable return component rate shall be determined or  
9 adjusted each July 1st by multiplying the facility's assigned  
10 percentage by the sum of the facility's July 1, 2001, therapy care,  
11 support services, and operations component rates, and its direct care  
12 cost per resident day for the preceding year.~~

13 ~~(e) Effective July 1, 2006,))~~

14 The variable return component rate allocation for each facility  
15 shall be the facility's June 30, 2006, variable return component rate  
16 allocation.

17 (2) The variable return rate allocation calculated in accordance  
18 with this section shall be adjusted to the extent necessary to comply  
19 with RCW 74.46.421.

20 **Sec. 6.** RCW 74.46.435 and 2001 1st sp.s. c 8 s 7 are each amended  
21 to read as follows:

22 (1) ~~((Effective July 1, 2001,))~~ The property component rate  
23 allocation for each facility shall be determined by dividing the sum of  
24 the reported allowable prior period actual depreciation, subject to  
25 ((RCW 74.46.310 through 74.46.380)) department rule, adjusted for any  
26 capitalized additions or replacements approved by the department, and  
27 the retained savings from such cost center, by the greater of a  
28 facility's total resident days for the facility in the prior period or  
29 resident days as calculated on ((~~eighty-five~~)) ninety percent facility  
30 occupancy for all providers except essential community providers.  
31 ~~((Effective July 1, 2002, the property component rate allocation for~~  
32 ~~all facilities, except essential community providers, shall be set by~~  
33 ~~using the greater of a facility's total resident days from the most~~  
34 ~~recent cost report period or resident days calculated at ninety percent~~  
35 ~~facility occupancy.)) If a capitalized addition or retirement of an~~  
36 ~~asset will result in a different licensed bed capacity during the~~

1 ensuing period, the prior period total resident days used in computing  
2 the property component rate shall be adjusted to anticipated resident  
3 day level.

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

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

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

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

27 **Sec. 7.** RCW 74.46.437 and 2001 1st sp.s. c 8 s 8 are each amended  
28 to read as follows:

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

34 (2) (~~Effective July 1, 2001,~~) The financing allowance shall be  
35 determined by multiplying the net invested funds of each facility by  
36 .10, and dividing by the greater of a nursing facility's total resident  
37 days from the most recent cost report period or resident days

1 calculated on (~~eighty-five~~) ninety percent facility occupancy for all  
2 providers except essential community providers. (~~Effective July 1,~~  
3 ~~2002, the financing allowance component rate allocation for all~~  
4 ~~facilities, other than essential community providers, shall be set by~~  
5 ~~using the greater of a facility's total resident days from the most~~  
6 ~~recent cost report period or resident days calculated at ninety percent~~  
7 ~~facility occupancy.~~) However, assets acquired on or after May 17,  
8 1999, shall be grouped in a separate financing allowance calculation  
9 that shall be multiplied by .085. The financing allowance factor of  
10 .085 shall not be applied to the net invested funds pertaining to new  
11 construction or major renovations receiving certificate of need  
12 approval or an exemption from certificate of need requirements under  
13 chapter 70.38 RCW, or to working drawings that have been submitted to  
14 the department of health for construction review approval, prior to May  
15 17, 1999. If a capitalized addition, renovation, replacement, or  
16 retirement of an asset will result in a different licensed bed capacity  
17 during the ensuing period, the prior period total resident days used in  
18 computing the financing allowance shall be adjusted to the greater of  
19 the anticipated resident day level or (~~eighty-five~~) ninety percent of  
20 the new licensed bed capacity for all providers except essential  
21 community providers. Effective July 1, 2002, for all facilities, other  
22 than essential community providers, the total resident days used to  
23 compute the financing allowance after a capitalized addition,  
24 renovation, replacement, or retirement of an asset shall be set by  
25 using the greater of a facility's total resident days from the most  
26 recent cost report period or resident days calculated at ninety percent  
27 facility occupancy.

28 (3) In computing the portion of net invested funds representing the  
29 net book value of tangible fixed assets, the same assets, depreciation  
30 bases, lives, and methods referred to in (~~RCW 74.46.330, 74.46.350,~~  
31 ~~74.46.360, 74.46.370, and 74.46.380~~) rule, including owned and leased  
32 assets, shall be utilized, except that the capitalized cost of land  
33 upon which the facility is located and such other contiguous land which  
34 is reasonable and necessary for use in the regular course of providing  
35 resident care shall also be included. Subject to provisions and  
36 limitations contained in this chapter, for land purchased by owners or  
37 lessors before July 18, 1984, capitalized cost of land shall be the  
38 buyer's capitalized cost. For all partial or whole rate periods after

1 July 17, 1984, if the land is purchased after July 17, 1984,  
2 capitalized cost shall be that of the owner of record on July 17, 1984,  
3 or buyer's capitalized cost, whichever is lower. In the case of leased  
4 facilities where the net invested funds are unknown or the contractor  
5 is unable to provide necessary information to determine net invested  
6 funds, the secretary shall have the authority to determine an amount  
7 for net invested funds based on an appraisal conducted according to  
8 ~~((RCW 74.46.360(1)))~~ department rule.

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

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

25 **Sec. 8.** RCW 74.46.439 and 1999 c 353 s 12 are each amended to read  
26 as follows:

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

36 ~~(a) The financing allowance shall be recomputed substituting the  
37 fair market value of the assets as of January 1, 1982, as determined by~~

1 the department of general administration through an appraisal  
2 procedure, less accumulated depreciation on the lessor's assets since  
3 January 1, 1982, for the net book value of the assets in determining  
4 net invested funds for the facility. A determination by the department  
5 of general administration of fair market value shall be final unless  
6 the procedure used to make such a determination is shown to be  
7 arbitrary and capricious.

8 (b) The sum of the financing allowance computed under (a) of this  
9 subsection and the variable return rate shall be compared to the  
10 annualized lease payment, plus any interest and depreciation associated  
11 with contractor-owned assets, for the period covered by the prospective  
12 rates, divided by the contractor's total resident days, minus the  
13 property component rate. The lesser of the two amounts shall be called  
14 the alternate return on investment rate.

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

19 (2) In the case of a facility that was leased by the contractor as  
20 of January 1, 1980, in an arm's length agreement, if the lease is  
21 renewed or extended under a provision of the lease, the treatment  
22 provided in subsection (1) of this section shall be applied, except  
23 that in the case of renewals or extensions made subsequent to April 1,  
24 1985, reimbursement for the annualized lease payment shall be no  
25 greater than the reimbursement for the annualized lease payment for the  
26 last year prior to the renewal or extension of the lease.

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

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

32 **Sec. 9.** RCW 74.46.475 and 1998 c 322 s 21 are each amended to read  
33 as follows:

34 ((+1)) The department shall analyze the submitted cost report or  
35 a portion thereof of each contractor for each report period to  
36 determine if the information is correct, complete, reported in  
37 conformance with department instructions and generally accepted

1 accounting principles, the requirements of this chapter, and such rules  
2 as the department may adopt. If the analysis finds that the cost  
3 report is incorrect or incomplete, the department may make adjustments  
4 to the reported information for purposes of establishing payment rate  
5 allocations. A schedule of such adjustments shall be provided to  
6 contractors and shall include an explanation for the adjustment and the  
7 dollar amount of the adjustment. Adjustments shall be subject to  
8 review and appeal as provided in this chapter.

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

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

13 ~~(b) Establishing rates.~~

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

16 **Sec. 10.** RCW 74.46.496 and 2006 c 258 s 4 are each amended to read  
17 as follows:

18 (1) Each case mix classification group shall be assigned a case mix  
19 weight. The case mix weight for each resident of a nursing facility  
20 for each calendar quarter shall be based on data from resident  
21 assessment instruments completed for the resident and weighted by the  
22 number of days the resident was in each case mix classification group.  
23 Days shall be counted as provided in this section.

24 (2) The case mix weights shall be based on the average minutes per  
25 registered nurse, licensed practical nurse, and certified nurse aide,  
26 for each case mix group, and using the ~~((health care financing  
27 administration of the))~~ United States department of health and human  
28 services 1995 nursing facility staff time measurement study stemming  
29 from its multistate nursing home case mix and quality demonstration  
30 project. Those minutes shall be weighted by statewide ratios of  
31 registered nurse to certified nurse aide, and licensed practical nurse  
32 to certified nurse aide, wages, including salaries and benefits, which  
33 shall be based on 1995 cost report data for this state.

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

35 (a) Set the certified nurse aide wage weight at 1.000 and calculate  
36 wage weights for registered nurse and licensed practical nurse average

1 wages by dividing the certified nurse aide average wage into the  
2 registered nurse average wage and licensed practical nurse average  
3 wage;

4 (b) Calculate the total weighted minutes for each case mix group in  
5 the resource utilization group III classification system by multiplying  
6 the wage weight for each worker classification by the average number of  
7 minutes that classification of worker spends caring for a resident in  
8 that resource utilization group III classification group, and summing  
9 the products;

10 (c) Assign a case mix weight of 1.000 to the resource utilization  
11 group III classification group with the lowest total weighted minutes  
12 and calculate case mix weights by dividing the lowest group's total  
13 weighted minutes into each group's total weighted minutes and rounding  
14 weight calculations to the third decimal place.

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

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

28 **Sec. 11.** RCW 74.46.501 and 2006 c 258 s 5 are each amended to read  
29 as follows:

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

35 (2)(a) In calculating a facility's two average case mix indexes for  
36 each quarter, the department shall include all residents or medicaid  
37 residents, as applicable, who were physically in the facility during

1 the quarter in question based on the resident assessment instrument  
2 completed by the facility and the requirements and limitations for the  
3 instrument's completion and transmission (January 1st through March  
4 31st, April 1st through June 30th, July 1st through September 30th, or  
5 October 1st through December 31st).

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

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

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

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

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

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

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

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

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

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

8       ~~(iii) If a new assessment is due for a resident or a new assessment~~  
9 ~~is completed and transmitted to the department, the end date of the~~  
10 ~~previous assessment shall be the earlier of either the day before the~~  
11 ~~assessment is due or the day before the assessment is completed by the~~  
12 ~~nursing facility)) specified by rule.~~

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

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

1 ~~census. If no census has been reported by a facility during a~~  
2 ~~specified quarter, then the department shall use the facility's~~  
3 ~~licensed beds as the denominator in computing the threshold.~~

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

12 (b) The facility average case mix index used to establish each  
13 nursing facility's direct care component rate shall be based on an  
14 average of calendar quarters of the facility's average case mix  
15 indexes((-

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

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

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

27 (c) The medicaid average case mix index used to update or  
28 recalibrate a nursing facility's direct care component rate quarterly  
29 shall be from the calendar quarter commencing six months prior to the  
30 effective date of the quarterly rate. For example, October 1, 1998,  
31 through December 31, 1998, direct care component rates shall utilize  
32 case mix averages from the April 1, 1998, through June 30, 1998,  
33 calendar quarter, and so forth.

34 **Sec. 12.** RCW 74.46.506 and 2007 c 508 s 3 are each amended to read  
35 as follows:

36 (1) The direct care component rate allocation corresponds to the  
37 provision of nursing care for one resident of a nursing facility for

1 one day, including direct care supplies. Therapy services and  
2 supplies, which correspond to the therapy care component rate, shall be  
3 excluded. The direct care component rate includes elements of case mix  
4 determined consistent with the principles of this section and other  
5 applicable provisions of this chapter.

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

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

23 (4) Cost report data used in setting direct care component rate  
24 allocations shall be for rate periods as specified in RCW  
25 74.46.431(4)(a).

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

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

37 (b) Divide each facility's total allowable direct care cost by its  
38 adjusted resident days for the same report period, (~~increased if~~

1 necessary to a minimum occupancy of eighty five percent; that is, the  
2 greater of actual or imputed occupancy at eighty five percent of  
3 licensed beds,)) to derive the facility's allowable direct care cost  
4 per resident day((. However, effective July 1, 2006, each facility's  
5 allowable direct care costs shall be divided by its adjusted resident  
6 days without application of a minimum occupancy assumption));

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

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

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

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

23 ((+g) Except as provided in (i) of this subsection, from October 1,  
24 1998, through June 30, 2000, determine each facility's quarterly direct  
25 care component rate as follows:

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

34 (ii) Any facility whose allowable cost per case mix unit is greater  
35 than one hundred fifteen percent of the peer group median established  
36 under (f) of this subsection shall be assigned a cost per case mix unit  
37 equal to one hundred fifteen percent of the peer group median, and  
38 shall have a direct care component rate allocation equal to the

1 facility's assigned cost per case mix unit multiplied by that  
2 facility's medicaid average case mix index from the applicable quarter  
3 specified in RCW 74.46.501(7)(c);

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

10 (h) Except as provided in (i) of this subsection, from July 1,  
11 2000, through June 30, 2006, determine each facility's quarterly direct  
12 care component rate as follows:

13 (i) Any facility whose allowable cost per case mix unit is less  
14 than ninety percent of the facility's peer group median established  
15 under (f) of this subsection shall be assigned a cost per case mix unit  
16 equal to ninety percent of the facility's peer group median, and shall  
17 have a direct care component rate allocation equal to the facility's  
18 assigned cost per case mix unit multiplied by that facility's medicaid  
19 average case mix index from the applicable quarter specified in RCW  
20 74.46.501(7)(c);

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

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

35 (i)(i) Between October 1, 1998, and June 30, 2000, the department  
36 shall compare each facility's direct care component rate allocation  
37 calculated under (g) of this subsection with the facility's nursing  
38 services component rate in effect on September 30, 1998, less therapy

1 costs, plus any exceptional care offsets as reported on the cost  
2 report, adjusted for economic trends and conditions as provided in RCW  
3 74.46.431. A facility shall receive the higher of the two rates.

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

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

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

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

26 (A) The department shall calculate:

27 (I) The sum of each facility's July 1, 2006, direct care component  
28 rate allocation calculated under (j) of this subsection and July 1,  
29 2006, operations component rate calculated under RCW 74.46.521; and

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

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

36 (C) If the sum calculated under (i)(v)(A)(I) of this subsection is  
37 greater than or equal to the sum calculated under (i)(v)(A)(II) of this

1 ~~subsection, the facility's direct care component rate shall be~~  
2 ~~calculated under (j) of this subsection;~~

3 ~~(j) Except as provided in (i) of this subsection, from July 1,~~  
4 ~~2006, forward, and for all future rate setting,)) (f) Determine each~~  
5 facility's quarterly direct care component rate as follows:

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

14 (ii) Any facility whose allowable cost per case mix unit is less  
15 than or equal to one hundred twelve percent of the peer group median  
16 established under (~~((f))~~) (e) of this subsection shall have a direct  
17 care component rate allocation equal to the facility's allowable cost  
18 per case mix unit multiplied by that facility's medicaid average case  
19 mix index from the applicable quarter specified in RCW 74.46.501(~~((7))~~)  
20 (6)(c).

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

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

31 **Sec. 13.** RCW 74.46.508 and 2003 1st sp.s. c 6 s 1 are each amended  
32 to read as follows:

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

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

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

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

11       **Sec. 14.** RCW 74.46.511 and 2008 c 263 s 3 are each amended to read  
12 as follows:

13       (1) The therapy care component rate allocation corresponds to the  
14 provision of medicaid one-on-one therapy provided by a qualified  
15 therapist as defined in this chapter, including therapy supplies and  
16 therapy consultation, for one day for one medicaid resident of a  
17 nursing facility. ~~((The therapy care component rate allocation for~~  
18 ~~October 1, 1998, through June 30, 2001, shall be based on adjusted~~  
19 ~~therapy costs and days from calendar year 1996. The therapy component~~  
20 ~~rate allocation for July 1, 2001, through June 30, 2007, shall be based~~  
21 ~~on adjusted therapy costs and days from calendar year 1999. Effective~~  
22 ~~July 1, 2007,))~~ The therapy care component rate allocation shall be  
23 based on adjusted therapy costs and days as described in RCW  
24 74.46.431(5). The therapy care component rate shall be adjusted for  
25 economic trends and conditions as specified in RCW 74.46.431(5), and  
26 shall be determined in accordance with this section. In determining  
27 each facility's therapy care component rate allocation, the department  
28 shall apply the applicable minimum facility occupancy adjustment before  
29 creating the array of facilities' adjusted therapy care costs per  
30 adjusted resident day.

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

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

36       (b) The total units or modules of therapy care for all residents by

1 type of therapy provided, for example, speech or physical. A unit or  
2 module of therapy care is considered to be fifteen minutes of one-on-  
3 one therapy provided by a qualified therapist or support personnel; and

4 (c) Therapy consulting expenses for all residents.

5 (3) The department shall determine for all residents the total cost  
6 per unit of therapy for each type of therapy by dividing the total  
7 adjusted one-on-one therapy expense for each type by the total units  
8 provided for that therapy type.

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

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

12 (b) Those located within nonurban counties.

13 The department shall array the facilities in each peer group from  
14 highest to lowest based on their total cost per unit of therapy for  
15 each therapy type. The department shall determine the median total  
16 cost per unit of therapy for each therapy type and add ten percent of  
17 median total cost per unit of therapy. The cost per unit of therapy  
18 for each therapy type at a nursing facility shall be the lesser of its  
19 cost per unit of therapy for each therapy type or the median total cost  
20 per unit plus ten percent for each therapy type for its peer group.

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

23 (a) To determine the allowable total therapy cost for each therapy  
24 type, the allowable cost per unit of therapy for each type of therapy  
25 shall be multiplied by the total therapy units for each type of  
26 therapy;

27 (b) The medicaid allowable one-on-one therapy expense shall be  
28 calculated taking the allowable total therapy cost for each therapy  
29 type times the medicaid percent of total therapy charges for each  
30 therapy type;

31 (c) The medicaid allowable one-on-one therapy expense for each  
32 therapy type shall be divided by total adjusted medicaid days to arrive  
33 at the medicaid one-on-one therapy cost per patient day for each  
34 therapy type;

35 (d) The medicaid one-on-one therapy cost per patient day for each  
36 therapy type shall be multiplied by total adjusted patient days for all  
37 residents to calculate the total allowable one-on-one therapy expense.  
38 The lesser of the total allowable therapy consultant expense for the

1 therapy type or a reasonable percentage of allowable therapy consultant  
2 expense for each therapy type, as established in rule by the  
3 department, shall be added to the total allowable one-on-one therapy  
4 expense to determine the allowable therapy cost for each therapy type;

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

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

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

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

20 **Sec. 15.** RCW 74.46.515 and 2008 c 263 s 4 are each amended to read  
21 as follows:

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

25 (2) (~~((Beginning October 1, 1998,))~~) The department shall determine  
26 each medicaid nursing facility's support services component rate  
27 allocation using cost report data specified by RCW 74.46.431(6).

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

30 (a) Array facilities' adjusted support services costs per adjusted  
31 resident day, as determined by dividing each facility's total allowable  
32 support services costs by its adjusted resident days for the same  
33 report period, increased if necessary to a minimum occupancy provided  
34 by RCW 74.46.431(2), for each facility from facilities' cost reports  
35 from the applicable report year, for facilities located within urban  
36 counties, and for those located within nonurban counties and determine  
37 the median adjusted cost for each peer group;

1 (b) Set each facility's support services component rate at the  
2 lower of the facility's per resident day adjusted support services  
3 costs from the applicable cost report period or the adjusted median per  
4 resident day support services cost for that facility's peer group,  
5 either urban counties or nonurban counties, plus ten percent; and

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

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

11 **Sec. 16.** RCW 74.46.521 and 2007 c 508 s 5 are each amended to read  
12 as follows:

13 (1) The operations component rate allocation corresponds to the  
14 general operation of a nursing facility for one resident for one day,  
15 including but not limited to management, administration, utilities,  
16 office supplies, accounting and bookkeeping, minor building  
17 maintenance, minor equipment repairs and replacements, and other  
18 supplies and services, exclusive of direct care, therapy care, support  
19 services, property, financing allowance, and variable return.

20 (~~Except as provided in subsection (4) of this section,~~  
21 ~~beginning October 1, 1998,~~) The department shall determine each  
22 medicaid nursing facility's operations component rate allocation using  
23 cost report data specified by RCW 74.46.431(7)(a). (~~Effective July 1,~~  
24 ~~2002,~~) Operations component rates for all facilities except essential  
25 community providers shall be based upon a minimum occupancy of ninety  
26 percent of licensed beds, and no operations component rate shall be  
27 revised in response to beds banked on or after May 25, 2001, under  
28 chapter 70.38 RCW.

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

32 (a) Array facilities' adjusted general operations costs per  
33 adjusted resident day, as determined by dividing each facility's total  
34 allowable operations cost by its adjusted resident days for the same  
35 report period, increased if necessary to a minimum occupancy of ninety  
36 percent; that is, the greater of actual or imputed occupancy at ninety  
37 percent of licensed beds, for each facility from facilities' cost

1 reports from the applicable report year, for facilities located within  
2 urban counties and for those located within nonurban counties and  
3 determine the median adjusted cost for each peer group;

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

5 (i) The facility's per resident day adjusted operations costs from  
6 the applicable cost report period adjusted if necessary to a minimum  
7 occupancy of (~~eighty five percent of licensed beds before July 1,~~  
8 ~~2002, and~~) ninety percent (~~effective July 1, 2002~~); or

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

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

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

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

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

27 **Sec. 17.** RCW 74.46.835 and 1998 c 322 s 46 are each amended to  
28 read as follows:

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

36 (2) Direct care component rates at the AIDS pilot facility shall be  
37 based on direct care reported costs at the pilot facility, utilizing

1 the same (~~three-year,~~) rate-setting cycle prescribed for other  
2 nursing facilities, and as supported by a staffing benchmark based upon  
3 a department-approved acuity measurement system.

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

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

8 **Sec. 18.** RCW 74.46.800 and 1998 c 322 s 42 are each amended to  
9 read as follows:

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

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

21 NEW SECTION. **Sec. 19.** The following acts or parts of acts are  
22 each repealed:

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

25 (2) RCW 74.46.040 (Due dates for cost reports) and 1998 c 322 s 3,  
26 1985 c 361 s 4, 1983 1st ex.s. c 67 s 1, & 1980 c 177 s 4;

27 (3) RCW 74.46.050 (Improperly completed or late cost report--  
28 Fines--Adverse rate actions--Rules) and 1998 c 322 s 4, 1985 c 361 s 5,  
29 & 1980 c 177 s 5;

30 (4) RCW 74.46.060 (Completing cost reports and maintaining records)  
31 and 1998 c 322 s 5, 1985 c 361 s 6, 1983 1st ex.s. c 67 s 2, & 1980 c  
32 177 s 6;

33 (5) RCW 74.46.080 (Requirements for retention of records by the  
34 contractor) and 1998 c 322 s 6, 1985 c 361 s 7, 1983 1st ex.s. c 67 s  
35 3, & 1980 c 177 s 8;

1 (6) RCW 74.46.090 (Retention of cost reports and resident  
2 assessment information by the department) and 1998 c 322 s 7, 1985 c  
3 361 s 8, & 1980 c 177 s 9;

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

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

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

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

17 (11) RCW 74.46.200 (Offset of miscellaneous revenues) and 1980 c  
18 177 s 20;

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

21 (13) RCW 74.46.230 (Initial cost of operation) and 1998 c 322 s 13,  
22 1993 sp.s. c 13 s 3, & 1980 c 177 s 23;

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

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

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

29 (17) RCW 74.46.280 (Management fees, agreements--Limitation on  
30 scope of services) and 1998 c 322 s 15, 1993 sp.s. c 13 s 4, & 1980 c  
31 177 s 28;

32 (18) RCW 74.46.290 (Expense for construction interest) and 1980 c  
33 177 s 29;

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

36 (20) RCW 74.46.310 (Capitalization) and 1983 1st ex.s. c 67 s 16 &  
37 1980 c 177 s 31;

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

1 (22) RCW 74.46.330 (Depreciable assets) and 1980 c 177 s 33;  
2 (23) RCW 74.46.340 (Land, improvements--Depreciation) and 1980 c  
3 177 s 34;  
4 (24) RCW 74.46.350 (Methods of depreciation) and 1999 c 353 s 13 &  
5 1980 c 177 s 35;  
6 (25) RCW 74.46.360 (Cost basis of land and depreciation base of  
7 depreciable assets) and 1999 c 353 s 2, 1997 c 277 s 1, 1991 sp.s. c 8  
8 s 18, & 1989 c 372 s 14;  
9 (26) RCW 74.46.370 (Lives of assets) and 1999 c 353 s 14, 1997 c  
10 277 s 2, & 1980 c 177 s 37;  
11 (27) RCW 74.46.380 (Depreciable assets) and 1993 sp.s. c 13 s 5,  
12 1991 sp.s. c 8 s 12, & 1980 c 177 s 38;  
13 (28) RCW 74.46.390 (Gains and losses upon replacement of  
14 depreciable assets) and 1980 c 177 s 39;  
15 (29) RCW 74.46.410 (Unallowable costs) and 2007 c 508 s 1, 2001 1st  
16 sp.s. c 8 s 3, 1998 c 322 s 17, 1995 1st sp.s. c 18 s 97, 1993 sp.s. c  
17 13 s 6, 1991 sp.s. c 8 s 15, 1989 c 372 s 2, 1986 c 175 s 3, 1983 1st  
18 ex.s. c 67 s 17, & 1980 c 177 s 41;  
19 (30) RCW 74.46.445 (Contractors--Rate adjustments) and 1999 c 353  
20 s 15;  
21 (31) RCW 74.46.533 (Combined and estimated rebased rates--  
22 Determination--Hold harmless provision) and 2007 c 508 s 6;  
23 (32) RCW 74.46.600 (Billing period) and 1980 c 177 s 60;  
24 (33) RCW 74.46.610 (Billing procedure--Rules) and 1998 c 322 s 32,  
25 1983 1st ex.s. c 67 s 33, & 1980 c 177 s 61;  
26 (34) RCW 74.46.620 (Payment) and 1998 c 322 s 33 & 1980 c 177 s 62;  
27 (35) RCW 74.46.625 (Supplemental payments) and 1999 c 392 s 1;  
28 (36) RCW 74.46.630 (Charges to patients) and 1998 c 322 s 34 & 1980  
29 c 177 s 63;  
30 (37) RCW 74.46.640 (Suspension of payments) and 1998 c 322 s 35,  
31 1995 1st sp.s. c 18 s 112, 1983 1st ex.s. c 67 s 34, & 1980 c 177 s 64;  
32 (38) RCW 74.46.650 (Termination of payments) and 1998 c 322 s 36 &  
33 1980 c 177 s 65;  
34 (39) RCW 74.46.660 (Conditions of participation) and 1998 c 322 s  
35 37, 1992 c 215 s 1, 1991 sp.s. c 8 s 13, & 1980 c 177 s 66;  
36 (40) RCW 74.46.680 (Change of ownership--Assignment of department's  
37 contract) and 1998 c 322 s 38, 1985 c 361 s 2, & 1980 c 177 s 68;

1 (41) RCW 74.46.690 (Change of ownership--Final reports--Settlement)  
2 and 1998 c 322 s 39, 1995 1st sp.s. c 18 s 113, 1985 c 361 s 3, 1983  
3 1st ex.s. c 67 s 36, & 1980 c 177 s 69;  
4 (42) RCW 74.46.700 (Resident personal funds--Records--Rules) and  
5 1991 sp.s. c 8 s 19 & 1980 c 177 s 70;  
6 (43) RCW 74.46.711 (Resident personal funds--Conveyance upon death  
7 of resident) and 2001 1st sp.s. c 8 s 14 & 1995 1st sp.s. c 18 s 69;  
8 (44) RCW 74.46.770 (Contractor appeals--Challenges of laws, rules,  
9 or contract provisions--Challenge based on federal law) and 1998 c 322  
10 s 40, 1995 1st sp.s. c 18 s 114, 1983 1st ex.s. c 67 s 39, & 1980 c 177  
11 s 77;  
12 (45) RCW 74.46.780 (Appeals or exception procedure) and 1998 c 322  
13 s 41, 1995 1st sp.s. c 18 s 115, 1989 c 175 s 159, 1983 1st ex.s. c 67  
14 s 40, & 1980 c 177 s 78;  
15 (46) RCW 74.46.790 (Denial, suspension, or revocation of license or  
16 provisional license--Penalties) and 1980 c 177 s 79;  
17 (47) RCW 74.46.820 (Public disclosure) and 2005 c 274 s 356, 1998  
18 c 322 s 43, 1985 c 361 s 14, 1983 1st ex.s. c 67 s 41, & 1980 c 177 s  
19 82;  
20 (48) RCW 74.46.900 (Severability--1980 c 177) and 1980 c 177 s 93;  
21 (49) RCW 74.46.901 (Effective dates--1983 1st ex.s. c 67; 1980 c  
22 177) and 1983 1st ex.s. c 67 s 49, 1981 1st ex.s. c 2 s 10, & 1980 c  
23 177 s 94;  
24 (50) RCW 74.46.902 (Section captions--1980 c 177) and 1980 c 177 s  
25 89;  
26 (51) RCW 74.46.905 (Severability--1983 1st ex.s. c 67) and 1983 1st  
27 ex.s. c 67 s 43; and  
28 (52) RCW 74.46.906 (Effective date--1998 c 322 §§ 1-37, 40-49, and  
29 52-54) and 1998 c 322 s 55.

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