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SENATE BILL 5727

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State of Washington

60th Legislature

2007 Regular Session

By Senators Keiser, Zarelli, Kohl-Welles, Roach, Benton, Pridemore, Franklin, Clements, Kilmer, Fairley, Kline, Kastama, Oemig, Kauffman and Rasmussen

Read first time 01/29/2007. Referred to Committee on Ways & Means.

1 AN ACT Relating to the nursing facility medicaid payment system;  
2 amending RCW 74.46.020, 74.46.165, 74.46.431, 74.46.433, 74.46.435,  
3 74.46.437, 74.46.439, 74.46.496, 74.46.501, 74.46.506, 74.46.508,  
4 74.46.511, 74.46.515, and 74.46.521; adding new sections to chapter  
5 74.46 RCW; providing an effective date; providing expiration dates; and  
6 declaring an emergency.

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

8 **Sec. 1.** RCW 74.46.020 and 2006 c 258 s 1 are each amended to read  
9 as follows:

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

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

16 (2) "Appraisal" means the process of estimating the fair market  
17 value or reconstructing the historical cost of an asset acquired in a  
18 past period as performed by a professionally designated real estate  
19 appraiser with no pecuniary interest in the property to be appraised.

1 It includes a systematic, analytic determination and the recording and  
2 analyzing of property facts, rights, investments, and values based on  
3 a personal inspection and inventory of the property.

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

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

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

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

25 (7) "Beneficial owner" means:

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

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

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

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

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

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

5 (ii) Through the conversion of an ownership interest;

6 (iii) Pursuant to the power to revoke a trust, discretionary  
7 account, or similar arrangement; or

8 (iv) Pursuant to the automatic termination of a trust,  
9 discretionary account, or similar arrangement;

10 except that, any person who acquires an ownership interest or power  
11 specified in (c)(i), (ii), or (iii) of this subsection with the purpose  
12 or effect of changing or influencing the control of the contractor, or  
13 in connection with or as a participant in any transaction having such  
14 purpose or effect, immediately upon such acquisition shall be deemed to  
15 be the beneficial owner of the ownership interest which may be acquired  
16 through the exercise or conversion of such ownership interest or power;

17 (d) Any person who in the ordinary course of business is a pledgee  
18 of ownership interest under a written pledge agreement shall not be  
19 deemed to be the beneficial owner of such pledged ownership interest  
20 until the pledgee has taken all formal steps necessary which are  
21 required to declare a default and determines that the power to vote or  
22 to direct the vote or to dispose or to direct the disposition of such  
23 pledged ownership interest will be exercised; except that:

24 (i) The pledgee agreement is bona fide and was not entered into  
25 with the purpose nor with the effect of changing or influencing the  
26 control of the contractor, nor in connection with any transaction  
27 having such purpose or effect, including persons meeting the conditions  
28 set forth in (b) of this subsection; and

29 (ii) The pledgee agreement, prior to default, does not grant to the  
30 pledgee:

31 (A) The power to vote or to direct the vote of the pledged  
32 ownership interest; or

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

37 (8) "Capital" means depreciation, financing allowance, and taxes.

1       (9) "Capitalization" means the recording of an expenditure as an  
2 asset.

3       ~~((+9))~~ (10) "Case mix" means a measure of the intensity of care  
4 and services needed by the residents of a nursing facility or a group  
5 of residents in the facility.

6       ~~((+10))~~ (11) "Case mix index" means a number representing the  
7 average case mix of a nursing facility.

8       ~~((+11))~~ (12) "Case mix weight" means a numeric score that  
9 identifies the relative resources used by a particular group of a  
10 nursing facility's residents.

11       ~~((+12))~~ (13) "Certificate of capital authorization" means a  
12 certification from the department for an allocation from the biennial  
13 capital financing authorization for all new or replacement building  
14 construction, or for major renovation projects, receiving a certificate  
15 of need or a certificate of need exemption under chapter 70.38 RCW  
16 after July 1, 2001.

17       ~~((+13))~~ (14) "Contractor" means a person or entity licensed under  
18 chapter 18.51 RCW to operate a medicare and medicaid certified nursing  
19 facility, responsible for operational decisions, and contracting with  
20 the department to provide services to medicaid recipients residing in  
21 the facility.

22       ~~((+14))~~ (15) "Default case" means no initial assessment has been  
23 completed for a resident and transmitted to the department by the  
24 cut-off date, or an assessment is otherwise past due for the resident,  
25 under state and federal requirements.

26       ~~((+15))~~ (16) "Department" means the department of social and  
27 health services (DSHS) and its employees.

28       ~~((+16))~~ (17) "Depreciation" means the systematic distribution of  
29 the cost or other basis of tangible assets, less salvage, over the  
30 estimated useful life of the assets.

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

34       (18) "Direct care one" means nursing care, including nurse aide  
35 care, provided to nursing facility residents.

36       (19) "Direct care supplies" means medical, pharmaceutical, and  
37 other supplies required for the direct care of a nursing facility's  
38 residents.

1        ~~((19))~~ (20) "Direct care two" means food, food preparation,  
2 dietary, housekeeping, laundry services, therapy, direct care supplies,  
3 and nursing-related services not included in direct care one. Nursing-  
4 related services include, but are not limited to, nursing direction and  
5 supervision, medical direction, medical records, pharmacy services,  
6 activities, and social services.

7        (21) "Entity" means an individual, partnership, corporation,  
8 limited liability company, or any other association of individuals  
9 capable of entering enforceable contracts.

10        ~~((20))~~ (22) "Equity" means the net book value of all tangible and  
11 intangible assets less the recorded value of all liabilities, as  
12 recognized and measured in conformity with generally accepted  
13 accounting principles.

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

17        ~~((22))~~ (23) "Facility" or "nursing facility" means a nursing home  
18 licensed in accordance with chapter 18.51 RCW, excepting nursing homes  
19 certified as institutions for mental diseases, or that portion of a  
20 multiservice facility licensed as a nursing home, or that portion of a  
21 hospital licensed in accordance with chapter 70.41 RCW which operates  
22 as a nursing home.

23        ~~((23))~~ (24) "Fair market value" means the replacement cost of an  
24 asset less observed physical depreciation on the date for which the  
25 market value is being determined.

26        ~~((24))~~ (25) "Financial statements" means statements prepared and  
27 presented in conformity with generally accepted accounting principles  
28 including, but not limited to, balance sheet, statement of operations,  
29 statement of changes in financial position, and related notes.

30        ~~((25))~~ (26) "Generally accepted accounting principles" means  
31 accounting principles approved by the financial accounting standards  
32 board (FASB).

33        ~~((26))~~ (27) "Goodwill" means the excess of the price paid for a  
34 nursing facility business over the fair market value of all net  
35 identifiable tangible and intangible assets acquired, as measured in  
36 accordance with generally accepted accounting principles.

37        ~~((27))~~ (28) "Grouper" means a computer software product that

1 groups individual nursing facility residents into case mix  
2 classification groups based on specific resident assessment data and  
3 computer logic.

4 ~~((+28+))~~ (29) "High labor-cost county" means an urban county in  
5 which the median allowable facility cost per case mix unit is more than  
6 ten percent higher than the median allowable facility cost per case mix  
7 unit among all other urban counties, excluding that county.

8 ~~((+29+))~~ (30) "Historical cost" means the actual cost incurred in  
9 acquiring and preparing an asset for use, including feasibility  
10 studies, architect's fees, and engineering studies.

11 ~~((+30+))~~ (31) "Home and central office costs" means costs that are  
12 incurred in the support and operation of a home and central office.  
13 Home and central office costs include centralized services that are  
14 performed in support of a nursing facility. The department may exclude  
15 from this definition costs that are nonduplicative, documented,  
16 ordinary, necessary, and related to the provision of care services to  
17 authorized patients.

18 ~~((+31+))~~ (32) "Imprest fund" means a fund which is regularly  
19 replenished in exactly the amount expended from it.

20 ~~((+32+))~~ (33) "Joint facility costs" means any costs which  
21 represent resources which benefit more than one facility, or one  
22 facility and any other entity.

23 ~~((+33+))~~ (34) "Lease agreement" means a contract between two  
24 parties for the possession and use of real or personal property or  
25 assets for a specified period of time in exchange for specified  
26 periodic payments. Elimination (due to any cause other than death or  
27 divorce) or addition of any party to the contract, expiration, or  
28 modification of any lease term in effect on January 1, 1980, or  
29 termination of the lease by either party by any means shall constitute  
30 a termination of the lease agreement. An extension or renewal of a  
31 lease agreement, whether or not pursuant to a renewal provision in the  
32 lease agreement, shall be considered a new lease agreement. A strictly  
33 formal change in the lease agreement which modifies the method,  
34 frequency, or manner in which the lease payments are made, but does not  
35 increase the total lease payment obligation of the lessee, shall not be  
36 considered modification of a lease term.

37 ~~((+34+))~~ (35) "Medicaid census" means the facility's total medicaid

1 days in a period divided by the facility's total resident days for the  
2 same period, including medicaid managed care.

3 (36) "Medical care program" or "medicaid program" means medical  
4 assistance, including nursing care, provided under RCW 74.09.500 or  
5 authorized state medical care services.

6 ~~((+35+))~~ (37) "Medical care recipient," "medicaid recipient," or  
7 "recipient" means an individual determined eligible by the department  
8 for the services provided under chapter 74.09 RCW.

9 ~~((+36+))~~ (38) "Minimum data set" means the overall data component  
10 of the resident assessment instrument, indicating the strengths, needs,  
11 and preferences of an individual nursing facility resident.

12 ~~((+37+))~~ (39) "Net book value" means the historical cost of an  
13 asset less accumulated depreciation.

14 ~~((+38+))~~ (40) "Net invested funds" means the net book value of  
15 tangible fixed assets employed by a contractor to provide services  
16 under the medical care program, including land, buildings, and  
17 equipment as recognized and measured in conformity with generally  
18 accepted accounting principles.

19 ~~((+39+))~~ (41) "Nonurban county" means a county which is not located  
20 in a metropolitan statistical area as determined and defined by the  
21 United States office of management and budget or other appropriate  
22 agency or office of the federal government.

23 ~~((+40+))~~ (42) "Operating lease" means a lease under which rental or  
24 lease expenses are included in current expenses in accordance with  
25 generally accepted accounting principles.

26 ~~((+41+))~~ (43) "Owner" means a sole proprietor, general or limited  
27 partners, members of a limited liability company, and beneficial  
28 interest holders of five percent or more of a corporation's outstanding  
29 stock.

30 ~~((+42+))~~ (44) "Ownership interest" means all interests beneficially  
31 owned by a person, calculated in the aggregate, regardless of the form  
32 which such beneficial ownership takes.

33 ~~((+43+))~~ (45) "Patient day" or "resident day" means a calendar day  
34 of care provided to a nursing facility resident, regardless of payment  
35 source, which will include the day of admission and exclude the day of  
36 discharge; except that, when admission and discharge occur on the same  
37 day, one day of care shall be deemed to exist. A "medicaid day" or  
38 "recipient day" means a calendar day of care provided to a medicaid

1 recipient determined eligible by the department for services provided  
2 under chapter 74.09 RCW, subject to the same conditions regarding  
3 admission and discharge applicable to a patient day or resident day of  
4 care.

5 ~~((44))~~ (46) "Professionally designated real estate appraiser"  
6 means an individual who is regularly engaged in the business of  
7 providing real estate valuation services for a fee, and who is deemed  
8 qualified by a nationally recognized real estate appraisal educational  
9 organization on the basis of extensive practical appraisal experience,  
10 including the writing of real estate valuation reports as well as the  
11 passing of written examinations on valuation practice and theory, and  
12 who by virtue of membership in such organization is required to  
13 subscribe and adhere to certain standards of professional practice as  
14 such organization prescribes.

15 ~~((45))~~ (47) "Qualified therapist" means:

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

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

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

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

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

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

30 ~~((46))~~ (48) "Rate" or "rate allocation" means the medicaid per-  
31 patient-day payment amount for medicaid patients calculated in  
32 accordance with the allocation methodology set forth in part E of this  
33 chapter.

34 ~~((47))~~ (49) "Real property," whether leased or owned by the  
35 contractor, means the building, allowable land, land improvements, and  
36 building improvements associated with a nursing facility.

37 ~~((48))~~ (50) "Rebased rate" or "cost-rebased rate" means a  
38 facility-specific component rate assigned to a nursing facility for a



1 particular rate period established on desk-reviewed, adjusted costs  
2 reported for that facility covering at least six months of a prior  
3 calendar year designated as a year to be used for cost-rebasing payment  
4 rate allocations under the provisions of this chapter.

5 ~~((49))~~ (51) "Records" means those data supporting all financial  
6 statements and cost reports including, but not limited to, all general  
7 and subsidiary ledgers, books of original entry, and transaction  
8 documentation, however such data are maintained.

9 ~~((50))~~ (52) "Related organization" means an entity which is under  
10 common ownership and/or control with, or has control of, or is  
11 controlled by, the contractor.

12 (a) "Common ownership" exists when an entity is the beneficial  
13 owner of five percent or more ownership interest in the contractor and  
14 any other entity.

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

19 ~~((51) "Related care" means only those services that are directly  
20 related to providing direct care to nursing facility residents. These  
21 services include, but are not limited to, nursing direction and  
22 supervision, medical direction, medical records, pharmacy services,  
23 activities, and social services.~~

24 ~~(52))~~ (53) "Resident assessment instrument," including federally  
25 approved modifications for use in this state, means a federally  
26 mandated, comprehensive nursing facility resident care planning and  
27 assessment tool, consisting of the minimum data set and resident  
28 assessment protocols.

29 ~~((53))~~ (54) "Resident assessment protocols" means those  
30 components of the resident assessment instrument that use the minimum  
31 data set to trigger or flag a resident's potential problems and risk  
32 areas.

33 ~~((54))~~ (55) "Resource utilization groups" means a case mix  
34 classification system that identifies relative resources needed to care  
35 for an individual nursing facility resident.

36 ~~((55))~~ (56) "Restricted fund" means those funds the principal  
37 and/or income of which is limited by agreement with or direction of the  
38 donor to a specific purpose.

1       ~~((56))~~ (57) "Seattle consumer price index" and "projected Seattle  
2 consumer price index" means the most recently available actual or  
3 projected percent change in the consumer price index for the  
4 Seattle-Tacoma-Bremerton, Washington consolidated metropolitan  
5 statistical area, as published by the Washington state economic and  
6 revenue forecast council established under RCW 82.33.020.

7       (58) "Secretary" means the secretary of the department of social  
8 and health services.

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

12       (58)) (59) "Therapy care" means those services required by a  
13 nursing facility resident's comprehensive assessment and plan of care,  
14 that are provided by qualified therapists, or support personnel under  
15 their supervision, including related costs as designated by the  
16 department.

17       ~~((59))~~ (60) "Title XIX" or "medicaid" means the 1965 amendments  
18 to the social security act, P.L. 89-07, as amended and the medicaid  
19 program administered by the department.

20       ~~((60))~~ (61) "Urban county" means a county which is located in a  
21 metropolitan statistical area as determined and defined by the United  
22 States office of management and budget or other appropriate agency or  
23 office of the federal government.

24       ~~((61) "Vital local provider" means a facility reporting a home~~  
25 ~~office that meets the following qualifications:~~

26       ~~(a) The home office address is located in Washington state; and~~

27       ~~(b) The sum of medicaid days for all Washington facilities~~  
28 ~~reporting the home office as their home office was greater than two~~  
29 ~~hundred fifteen thousand in 2003.)~~

30       **Sec. 2.** RCW 74.46.165 and 2001 1st sp.s. c 8 s 2 are each amended  
31 to read as follows:

32       (1) Contractors shall be required to submit with each annual  
33 nursing facility cost report a proposed settlement report showing  
34 underspending or overspending in each component rate during the cost  
35 report year on a per-resident day basis. The department shall accept  
36 or reject the proposed settlement report, explain any adjustments, and  
37 issue a revised settlement report if needed.

1 (2) Contractors shall not be required to refund payments made in  
2 the operations, variable return, property, and financing allowance  
3 component rates in excess of the adjusted costs of providing services  
4 corresponding to these components.

5 (3) The facility will return to the department any overpayment  
6 amounts in each of the direct care, therapy care, and support services  
7 rate components that the department identifies following the audit and  
8 settlement procedures as described in this chapter, provided that the  
9 contractor may retain any overpayment that does not exceed 1.0% of the  
10 facility's direct care, therapy care, and support services component  
11 rate. However, no overpayments may be retained in a cost center to  
12 which savings have been shifted to cover a deficit, as provided in  
13 subsection (4) of this section. Facilities that are not in substantial  
14 compliance for more than ninety days, and facilities that provide  
15 substandard quality of care at any time, during the period for which  
16 settlement is being calculated, will not be allowed to retain any  
17 amount of overpayment in the facility's direct care, therapy care, and  
18 support services component rate. The terms "not in substantial  
19 compliance" and "substandard quality of care" shall be defined by  
20 federal survey regulations.

21 (4) Determination of unused rate funds, including the amounts of  
22 direct care, therapy care, and support services to be recovered, shall  
23 be done separately for each component rate, and, except as otherwise  
24 provided in this subsection, neither costs nor rate payments shall be  
25 shifted from one component rate or corresponding service area to  
26 another in determining the degree of underspending or recovery, if any.  
27 In computing a preliminary or final settlement, savings in the support  
28 services cost center shall be shifted to cover a deficit in the direct  
29 care or therapy cost centers up to the amount of any savings, but no  
30 more than twenty percent of the support services component rate may be  
31 shifted. In computing a preliminary or final settlement, savings in  
32 direct care and therapy care may be shifted to cover a deficit in these  
33 two cost centers up to the amount of savings in each, regardless of the  
34 percentage of either component rate shifted. Contractor-retained  
35 overpayments up to one percent of direct care, therapy care, and  
36 support services rate components, as authorized in subsection (3) of  
37 this section, shall be calculated and applied after all shifting is  
38 completed.

1 (5) Total and component payment rates assigned to a nursing  
2 facility, as calculated and revised, if needed, under the provisions of  
3 this chapter and those rules as the department may adopt, shall  
4 represent the maximum payment for nursing facility services rendered to  
5 medicaid recipients for the period the rates are in effect. No  
6 increase in payment to a contractor shall result from spending above  
7 the total payment rate or in any rate component.

8 (6) RCW 74.46.150 through 74.46.180, and rules adopted by the  
9 department prior to July 1, 1998, shall continue to govern the medicaid  
10 settlement process for periods prior to October 1, 1998, as if these  
11 statutes and rules remained in full force and effect.

12 (7) For calendar year ~~((1998))~~ 2007, the department shall calculate  
13 split settlements covering January 1, ~~((1998))~~ 2007, through  
14 ~~((September))~~ June 30, ~~((1998))~~ 2007, and ~~((October))~~ July 1, ~~((1998))~~  
15 2007, through December 31, ~~((1998))~~ 2007. ~~((For the period beginning~~  
16 ~~October 1, 1998, rules specified in this chapter shall apply.))~~ The  
17 department shall use the provisions of this section for the January 1,  
18 2007, through June 30, 2007, settlement. The provisions of this  
19 section shall not apply to rate settings or costs occurring July 1,  
20 2007, or later. The department shall, by rule, determine the division  
21 of calendar year ~~((1998))~~ 2007 adjusted costs for settlement purposes.

22 (8) This section expires December 31, 2008.

23 NEW SECTION. Sec. 3. A new section is added to chapter 74.46 RCW  
24 to read as follows:

25 (1) Contractors shall be required to submit with each annual  
26 nursing facility cost report a proposed settlement report showing  
27 underspending or overspending in each component rate during the cost  
28 report year on a per resident day basis. The department shall accept  
29 or reject the proposed settlement report, explain any adjustments, and  
30 issue a revised settlement report if needed.

31 (2) Contractors shall not be required to refund payments made in  
32 the operations, capital, and disproportionate medicaid component rates  
33 in excess of the adjusted costs of providing services corresponding to  
34 these components.

35 (3) The facility shall return to the department any overpayment  
36 amounts in each of the direct care one and direct care two component  
37 rates that the department identifies following the audit and settlement

1 procedures as described in this chapter, provided that the contractor  
2 may retain any overpayment that does not exceed one percent of the  
3 facility's direct care one and direct care two component rates.  
4 Facilities that are not in substantial compliance for more than ninety  
5 days, and facilities that provide substandard quality of care at any  
6 time, during the period for which settlement is being calculated, will  
7 not be allowed to retain any amount of overpayment in the facility's  
8 direct care one and direct care two component rates. The terms "not in  
9 substantial compliance" and "substandard quality of care" shall be  
10 defined by federal survey regulations.

11 (4) Determination of unused rate funds, including the amounts of  
12 direct care one and direct care two to be recovered, shall be done  
13 separately for each component rate and neither costs nor rate payments  
14 shall be shifted from one component rate or corresponding service area  
15 to another in determining the degree of underspending or recovery, if  
16 any.

17 (5) Total and component payment rates assigned to a nursing  
18 facility, as calculated and revised, if needed, under the provisions of  
19 this chapter and those rules as the department may adopt, shall  
20 represent the maximum payment for nursing facility services rendered to  
21 medicaid recipients for the period the rates are in effect. No  
22 increase in payment to a contractor shall result from spending above  
23 the total payment rate or in any component rate.

24 (6) RCW 74.46.165 and rules adopted by the department prior to July  
25 1, 2007, shall continue to govern the medicaid settlement process for  
26 periods prior to July 1, 2007, as if these statutes and rules remained  
27 in full force and effect.

28 (7) For calendar year 2007, the department shall calculate split  
29 settlements covering January 1, 2007, through June 30, 2007, and July  
30 1, 2007, through December 31, 2007, under the provisions of this  
31 section and RCW 74.46.165. The department shall, by rule, determine  
32 the division of calendar year 2007 adjusted costs for settlement  
33 purposes.

34 **Sec. 4.** RCW 74.46.431 and 2006 c 258 s 2 are each amended to read  
35 as follows:

36 (1) Effective July 1, 1999, nursing facility medicaid payment rate  
37 allocations shall be facility-specific and shall have seven components:

1 Direct care, therapy care, support services, operations, property,  
2 financing allowance, and variable return. The department shall  
3 establish and adjust each of these components, as provided in this  
4 section and elsewhere in this chapter, for each medicaid nursing  
5 facility in this state.

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

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. Adjusted  
30 cost report data from 1996 will be used for October 1, 1998, through  
31 June 30, 2001, direct care component rate allocations; adjusted cost  
32 report data from 1999 will be used for July 1, 2001, through June 30,  
33 2006, direct care component rate allocations. Adjusted cost report  
34 data from 2003 will be used for July 1, 2006, and later direct care  
35 component rate allocations.

36 (b) Direct care component rate allocations based on 1996 cost  
37 report data shall be adjusted annually for economic trends and  
38 conditions by a factor or factors defined in the biennial

1 appropriations act. A different economic trends and conditions  
2 adjustment factor or factors may be defined in the biennial  
3 appropriations act for facilities whose direct care component rate is  
4 set equal to their adjusted June 30, 1998, rate, as provided in RCW  
5 74.46.506(5)(i).

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

14 (d) Direct care component rate allocations based on 2003 cost  
15 report data shall be adjusted annually for economic trends and  
16 conditions by a factor or factors defined in the biennial  
17 appropriations act. A different economic trends and conditions  
18 adjustment factor or factors may be defined in the biennial  
19 appropriations act for facilities whose direct care component rate is  
20 set equal to their adjusted June 30, 2006, rate, as provided in RCW  
21 74.46.506(5)(i).

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

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

33 (6)(a) Support services component rate allocations shall be  
34 established using adjusted cost report data covering at least six  
35 months. Adjusted cost report data from 1996 shall be used for October  
36 1, 1998, through June 30, 2001, support services component rate  
37 allocations; adjusted cost report data from 1999 shall be used for July  
38 1, 2001, through June 30, 2005, support services component rate

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

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

7 (7)(a) Operations component rate allocations shall be established  
8 using adjusted cost report data covering at least six months. Adjusted  
9 cost report data from 1996 shall be used for October 1, 1998, through  
10 June 30, 2001, operations component rate allocations; adjusted cost  
11 report data from 1999 shall be used for July 1, 2001, through June 30,  
12 2006, operations component rate allocations. Adjusted cost report data  
13 from 2003 will be used for July 1, 2006, and later operations component  
14 rate allocations.

15 (b) Operations component rate allocations shall be adjusted  
16 annually for economic trends and conditions by a factor or factors  
17 defined in the biennial appropriations act. A different economic  
18 trends and conditions adjustment factor or factors may be defined in  
19 the biennial appropriations act for facilities whose operations  
20 component rate is set equal to their adjusted June 30, 2006, rate, as  
21 provided in RCW 74.46.521(4).

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

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

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

35 (11) The department shall establish in rule procedures, principles,  
36 and conditions for determining component rate allocations for  
37 facilities in circumstances not directly addressed by this chapter,  
38 including but not limited to: The need to prorate inflation for



1 partial-period cost report data, newly constructed facilities, existing  
2 facilities entering the medicaid program for the first time or after a  
3 period of absence from the program, existing facilities with expanded  
4 new bed capacity, existing medicaid facilities following a change of  
5 ownership of the nursing facility business, facilities banking beds or  
6 converting beds back into service, facilities temporarily reducing the  
7 number of set-up beds during a remodel, facilities having less than six  
8 months of either resident assessment, cost report data, or both, under  
9 the current contractor prior to rate setting, and other circumstances.

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

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

31 (14) Facilities obtaining a certificate of need or a certificate of  
32 need exemption under chapter 70.38 RCW after June 30, 2001, must have  
33 a certificate of capital authorization in order for (a) the  
34 depreciation resulting from the capitalized addition to be included in  
35 calculation of the facility's property component rate allocation; and  
36 (b) the net invested funds associated with the capitalized addition to  
37 be included in calculation of the facility's financing allowance rate  
38 allocation.

1       (15) This section expires July 1, 2007.

2       NEW SECTION.   **Sec. 5.**   A new section is added to chapter 74.46 RCW  
3 to read as follows:

4       (1) Effective July 1, 2007, nursing facility medicaid payment rate  
5 allocations shall be facility-specific and shall have five components:  
6 (a) Direct care one, (b) direct care two, (c) operations, (d) capital,  
7 and (e) disproportionate medicaid. The department shall establish and  
8 adjust each of these components, as provided in this section and  
9 elsewhere in this chapter, for each medicaid nursing facility in this  
10 state.

11       (2) Direct care one, direct care two, and operations component rate  
12 allocations shall be established using adjusted cost report data  
13 covering at least six months. Effective July 1, 2007, direct care one,  
14 direct care two, and operations component rate allocations shall be  
15 established using 2005 cost report data. The direct care one, direct  
16 care two, and operations component rate allocations shall be rebased  
17 biennially, so that effective July 1st of each odd year following 2007,  
18 the direct care one, direct care two, and operations component rate  
19 allocations shall be established using cost report data from the  
20 preceding odd calendar year. For example, 2007 costs shall be used for  
21 direct care one, direct care two, and operations component rate  
22 allocations beginning July 1, 2009, and so forth.

23       (3) Direct care one, direct care two, and operations component rate  
24 allocations shall be adjusted for economic trends and conditions by  
25 five and one-quarter percent for the July 1, 2007, rate setting, and by  
26 an additional three percent for the July 1, 2008, rate setting. Direct  
27 care one, direct care two, and operations component rate allocations  
28 shall be adjusted annually for economic trends and conditions by the  
29 following factors in future years:

30       (a) For the July 1, 2009, rate setting, and for each rate setting  
31 July 1st of subsequent odd-numbered years, the factor shall be set at:

32       (i) The sum of the projected Seattle consumer price index from the  
33 midpoint of the cost year to the midpoint of the rate year. For  
34 example, the factor used for the July 1, 2009, rate setting would be  
35 the sum of half of the 2007 Seattle consumer price index, plus the  
36 projected 2008 Seattle consumer price index, plus the projected 2009  
37 Seattle consumer price index; and so forth.

1 (ii) If the sum calculated in (a)(i) of this subsection is greater  
2 than six percent, the factor shall be six percent.

3 (iii) If the sum calculated in (a)(i) of this subsection is less  
4 than five percent, the factor shall be five percent.

5 (b) For the July 1, 2010, rate setting, and for each rate setting  
6 July 1st of subsequent even-numbered years, the factor shall be set at  
7 the amount calculated in (a) of this subsection added to:

8 (i) The projected Seattle consumer price index from the calendar  
9 year corresponding to the beginning of the rate year. For example, the  
10 calendar year 2010 projected Seattle consumer price index for the July  
11 1, 2010, rate setting; and so forth.

12 (ii) If the factor calculated in (b)(i) of this subsection is  
13 greater than three percent, the factor shall be three percent.

14 (iii) If the factor calculated in (b)(ii) of this subsection is  
15 less than two percent, the factor shall be two percent.

16 (4) Information and data sources used in determining medicaid  
17 payment rate allocations, including formulas, procedures, cost report  
18 periods, resident assessment instrument formats, resident assessment  
19 methodologies, and resident classification and case mix weighting  
20 methodologies, may be substituted or altered from time to time as  
21 determined by the department.

22 (5) Total payment rates under the nursing facility medicaid payment  
23 system shall not exceed facility rates charged to the general public  
24 for comparable services.

25 (6) Medicaid contractors shall pay to all facility staff a minimum  
26 wage of the greater of the state minimum wage or the federal minimum  
27 wage.

28 (7) The department shall establish in rule procedures, principles,  
29 and conditions for determining component rate allocations for  
30 facilities in circumstances not directly addressed by this chapter,  
31 including but not limited to the need to prorate inflation for  
32 partial-period cost report data, newly constructed facilities, existing  
33 facilities entering the medicaid program for the first time or after a  
34 period of absence from the program, existing facilities with expanded  
35 new bed capacity, existing medicaid facilities following a change of  
36 ownership of the nursing facility business, facilities banking beds or  
37 converting beds back into service, facilities temporarily reducing the

1 number of set-up beds during a remodel, facilities having less than six  
2 months of either resident assessment, cost report data, or both, under  
3 the current contractor prior to rate setting, and other circumstances.

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

9 (9) Facilities obtaining a certificate of need or a certificate of  
10 need exemption under chapter 70.38 RCW after June 30, 2001, must have  
11 a certificate of capital authorization in order for (a) the  
12 depreciation resulting from the capitalized addition to be included in  
13 calculation of the facility's property component rate allocation; and  
14 (b) the net invested funds associated with the capitalized addition to  
15 be included in calculation of the facility's financing allowance rate  
16 allocation.

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

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

22 (a) Except as provided in (e) of this subsection, the variable  
23 return array and percentage shall be assigned whenever rebasing of  
24 noncapital rate allocations is scheduled under RCW 74.46.431 (4), (5),  
25 (6), and (7).

26 (b) To calculate the array of facilities for the July 1, 2001, rate  
27 setting, the department, without using peer groups, shall first rank  
28 all facilities in numerical order from highest to lowest according to  
29 each facility's examined and documented, but unlidded, combined direct  
30 care, therapy care, support services, and operations per resident day  
31 cost from the 1999 cost report period. However, before being combined  
32 with other per resident day costs and ranked, a facility's direct care  
33 cost per resident day shall be adjusted to reflect its facility average  
34 case mix index, to be averaged from the four calendar quarters of 1999,  
35 weighted by the facility's resident days from each quarter, under RCW  
36 74.46.501(7)(b)(ii). The array shall then be divided into four  
37 quartiles, each containing, as nearly as possible, an equal number of

1 facilities, and four percent shall be assigned to facilities in the  
2 lowest quartile, three percent to facilities in the next lowest  
3 quartile, two percent to facilities in the next highest quartile, and  
4 one percent to facilities in the highest quartile.

5 (c) The department shall, subject to (d) of this subsection,  
6 compute the variable return allowance by multiplying a facility's  
7 assigned percentage by the sum of the facility's direct care, therapy  
8 care, support services, and operations component rates determined in  
9 accordance with this chapter and rules adopted by the department.

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

20 (e) Effective July 1, 2006, the variable return component rate  
21 allocation for each facility shall be the facility's June 30, 2006,  
22 variable return component rate allocation.

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

26 (3) This section expires July 1, 2007.

27 NEW SECTION. **Sec. 7.** A new section is added to chapter 74.46 RCW  
28 to read as follows:

29 (1) Effective July 1, 2007, the department shall establish for each  
30 medicaid nursing facility a disproportionate medicaid component rate  
31 allocation.

32 (2) The disproportionate medicaid array and percentage shall be  
33 assigned whenever rebasing of the direct care one, direct care two, and  
34 operations component rates is scheduled to occur.

35 (3) The disproportionate medicaid component rate allocation shall  
36 be determined as follows:

1 (a) To calculate the array of facilities, the department, without  
2 using peer groups, shall first rank all facilities in numerical order  
3 from highest to lowest according to each facility's medicaid census  
4 from the rebase year. The array shall then be divided into four  
5 quartiles, each containing, as nearly as possible, an equal number of  
6 facilities, and four percent shall be assigned to facilities in the  
7 highest quartile, three percent to facilities in the next highest  
8 quartile, two percent to facilities in the next lowest quartile, and  
9 one percent to facilities in the lowest quartile.

10 (b) The department shall compute the disproportionate medicaid  
11 component rate by multiplying a facility's assigned percentage  
12 calculated in this subsection (3)(b) by the sum of the facility's  
13 direct care one, direct care two, and operations component rates  
14 determined in accordance with this chapter and rules adopted by the  
15 department.

16 (4) The disproportionate medicaid rate allocation calculated in  
17 accordance with this section shall be adjusted to the extent necessary  
18 to comply with RCW 74.46.421.

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

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

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

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

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

21 (5) The property 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 (6) This section expires July 1, 2007.

25 **Sec. 9.** RCW 74.46.437 and 2001 1st sp.s. c 8 s 8 are each amended  
26 to read as follows:

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

32 (2) Effective July 1, 2001, the financing allowance shall be  
33 determined by multiplying the net invested funds of each facility by  
34 .10, and dividing by the greater of a nursing facility's total resident  
35 days from the most recent cost report period or resident days  
36 calculated on eighty-five percent facility occupancy. Effective July  
37 1, 2002, the financing allowance component rate allocation for all

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

24 (3) In computing the portion of net invested funds representing the  
25 net book value of tangible fixed assets, the same assets, depreciation  
26 bases, lives, and methods referred to in RCW 74.46.330, 74.46.350,  
27 74.46.360, 74.46.370, and 74.46.380, including owned and leased assets,  
28 shall be utilized, except that the capitalized cost of land upon which  
29 the facility is located and such other contiguous land which is  
30 reasonable and necessary for use in the regular course of providing  
31 resident care shall also be included. Subject to provisions and  
32 limitations contained in this chapter, for land purchased by owners or  
33 lessors before July 18, 1984, capitalized cost of land shall be the  
34 buyer's capitalized cost. For all partial or whole rate periods after  
35 July 17, 1984, if the land is purchased after July 17, 1984,  
36 capitalized cost shall be that of the owner of record on July 17, 1984,  
37 or buyer's capitalized cost, whichever is lower. In the case of leased  
38 facilities where the net invested funds are unknown or the contractor



1 is unable to provide necessary information to determine net invested  
2 funds, the secretary shall have the authority to determine an amount  
3 for net invested funds based on an appraisal conducted according to RCW  
4 74.46.360(1).

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

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

21 (6) This section expires July 1, 2007.

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

24 (1) Effective July 1, 2007, the department shall establish for each  
25 medicaid nursing facility a capital component rate allocation. The  
26 capital component rate shall be rebased annually, effective July 1st,  
27 in accordance with the provisions of this section and this chapter.

28 (2) The capital component rate allocation for each facility shall  
29 be determined by:

30 (a) Summing the following:

31 (i) The sum of the reported allowable prior period actual  
32 depreciation, subject to RCW 74.46.310 through 74.46.380, adjusted for  
33 any capitalized additions or replacements approved by the department,  
34 and the retained savings from such cost center;

35 (ii) For net invested funds acquired prior to May 17, 1999, and for  
36 net invested funds pertaining to new construction or major renovations  
37 receiving certificate of need approval or an exemption from certificate

1 of need requirements under chapter 70.38 RCW, and for working drawings  
2 that have been submitted to the department of health for construction  
3 review approval, prior to May 17, 1999, the facility's net invested  
4 funds multiplied by .10;

5 (iii) For net invested funds acquired on or after May 17, 1999 and  
6 not otherwise included in (a)(ii) of this subsection, the facility's  
7 net invested funds multiplied by .085;

8 (iv) The sum of reported real estate, personal property, and  
9 business and occupation taxes. Any taxes paid as a quality maintenance  
10 fee under RCW 82.71.020 shall not be included in this sum;

11 (b) Dividing the sum calculated in (a) of this subsection by the  
12 facility's actual resident days. If a capitalized addition or  
13 retirement of an asset will result in a different licensed bed capacity  
14 during the ensuing period, the prior period total resident days used in  
15 computing the property component rate shall be adjusted to anticipated  
16 resident day level.

17 (3) In computing the portion of net invested funds representing the  
18 net book value of tangible fixed assets, the same assets, depreciation  
19 bases, lives, and methods referred to in RCW 74.46.330, 74.46.350,  
20 74.46.360, 74.46.370, and 74.46.380, including owned and leased assets,  
21 shall be utilized, except that the capitalized cost of land upon which  
22 the facility is located and such other contiguous land which is  
23 reasonable and necessary for use in the regular course of providing  
24 resident care shall also be included. Subject to provisions and  
25 limitations contained in this chapter, for land purchased by owners or  
26 lessors before July 18, 1984, capitalized cost of land shall be the  
27 buyer's capitalized cost. For all partial or whole rate periods after  
28 July 17, 1984, if the land is purchased after July 17, 1984,  
29 capitalized cost shall be that of the owner of record on July 17, 1984,  
30 or buyer's capitalized cost, whichever is lower. In the case of leased  
31 facilities where the net invested funds are unknown or the contractor  
32 is unable to provide necessary information to determine net invested  
33 funds, the secretary shall have the authority to determine an amount  
34 for net invested funds based on an appraisal conducted according to RCW  
35 74.46.360(1).

36 (4) When a certificate of need for a new facility is requested, the  
37 department, in reaching its decision, shall take into consideration per

1 bed land and building construction costs for the facility which shall  
2 not exceed a maximum to be established by the secretary.

3 (5) The capital component rate allocations calculated in accordance  
4 with this section shall be adjusted to the extent necessary to comply  
5 with RCW 74.46.421.

6 **Sec. 11.** RCW 74.46.439 and 1999 c 353 s 12 are each amended to  
7 read as follows:

8 (1) In the case of a facility that was leased by the contractor as  
9 of January 1, 1980, in an arm's-length agreement, which continues to be  
10 leased under the same lease agreement, and for which the annualized  
11 lease payment, plus any interest and depreciation expenses associated  
12 with contractor-owned assets, for the period covered by the prospective  
13 rates, divided by the contractor's total resident days, minus the  
14 property component rate allocation, is more than the sum of the  
15 financing allowance and the variable return rate determined according  
16 to this chapter, the following shall apply:

17 (a) The financing allowance shall be recomputed substituting the  
18 fair market value of the assets as of January 1, 1982, as determined by  
19 the department of general administration through an appraisal  
20 procedure, less accumulated depreciation on the lessor's assets since  
21 January 1, 1982, for the net book value of the assets in determining  
22 net invested funds for the facility. A determination by the department  
23 of general administration of fair market value shall be final unless  
24 the procedure used to make such a determination is shown to be  
25 arbitrary and capricious.

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

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

1 (2) In the case of a facility that was leased by the contractor as  
2 of January 1, 1980, in an arm's-length agreement, if the lease is  
3 renewed or extended under a provision of the lease, the treatment  
4 provided in subsection (1) of this section shall be applied, except  
5 that in the case of renewals or extensions made subsequent to April 1,  
6 1985, reimbursement for the annualized lease payment shall be no  
7 greater than the reimbursement for the annualized lease payment for the  
8 last year prior to the renewal or extension of the lease.

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

12 (4) This section expires July 1, 2007.

13 **Sec. 12.** RCW 74.46.496 and 2006 c 258 s 4 are each amended to read  
14 as follows:

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

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

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

32 (a) Set the certified nurse aide wage weight at 1.000 and calculate  
33 wage weights for registered nurse and licensed practical nurse average  
34 wages by dividing the certified nurse aide average wage into the  
35 registered nurse average wage and licensed practical nurse average  
36 wage;

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

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

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

22 (5) Case mix weights shall be revised when direct care one  
23 component rates are cost-rebased as provided in ((RCW 74.46.431(4)))  
24 section 5(2) of this act.

25 **Sec. 13.** RCW 74.46.501 and 2006 c 258 s 5 are each amended to read  
26 as follows:

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

32 (2)(a) In calculating a facility's two average case mix indexes for  
33 each quarter, the department shall include all residents or medicaid  
34 residents, as applicable, who were physically in the facility during  
35 the quarter in question based on the resident assessment instrument  
36 completed by the facility and the requirements and limitations for the

1 instrument's completion and transmission (January 1st through March  
2 31st, April 1st through June 30th, July 1st through September 30th, or  
3 October 1st through December 31st).

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

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

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

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

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

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

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

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

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

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

5 (iii) If a new assessment is due for a resident or a new assessment  
6 is completed and transmitted to the department, the end date of the  
7 previous assessment shall be the earlier of either the day before the  
8 assessment is due or the day before the assessment is completed by the  
9 nursing facility.

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

16 (6) A threshold of ninety percent, as described and calculated in  
17 this subsection, shall be used to determine the case mix index each  
18 quarter. The threshold shall also be used to determine which  
19 facilities' costs per case mix unit are included in determining the  
20 ceiling, floor, and price. (~~For direct care component rate~~  
21 ~~allocations established on and after July 1, 2006,~~) The threshold of  
22 ninety percent shall be used to determine the case mix index each  
23 quarter and to determine which facilities' costs per case mix unit are  
24 included in determining the ceiling and price. If the facility does  
25 not meet the ninety percent threshold, the department may use an  
26 alternate case mix index to determine the facility average and medicaid  
27 average case mix indexes for the quarter. The threshold is a count of  
28 unique minimum data set assessments, and it shall include resident  
29 assessment instrument tracking forms for residents discharged prior to  
30 completing an initial assessment. The threshold is calculated by  
31 dividing a facility's count of residents being assessed by the average  
32 census for the facility. A daily census shall be reported by each  
33 nursing facility as it transmits assessment data to the department.  
34 The department shall compute a quarterly average census based on the  
35 daily census. If no census has been reported by a facility during a  
36 specified quarter, then the department shall use the facility's  
37 licensed beds as the denominator in computing the threshold.

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

9 (b) The facility average case mix index used to establish each  
10 nursing facility's direct care one component rate shall be based on an  
11 average of calendar quarters of the facility's average case mix  
12 indexes.

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

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

19 (~~iii~~)) Beginning on July 1, 2006, when establishing the direct  
20 care one component rates, the department shall use an average of  
21 facility case mix indexes from the four calendar quarters occurring  
22 during the cost report period used to rebase the direct care component  
23 rate allocations as specified in ((RCW ~~74.46.431~~)) section 5 of this  
24 act.

25 (c) The medicaid average case mix index used to update or  
26 recalibrate a nursing facility's direct care one component rate  
27 quarterly shall be from the calendar quarter commencing six months  
28 prior to the effective date of the quarterly rate. For example,  
29 ((~~October~~)) July 1, ((~~1998~~)) 2007, through ((~~December 31, 1998~~))  
30 September 30, 2007, direct care component rates shall utilize case mix  
31 averages from the ((~~April~~)) January 1, ((~~1998~~)) 2007, through ((~~June~~))  
32 March 30, ((~~1998~~)) 2007, calendar quarter, and so forth.

33 **Sec. 14.** RCW 74.46.506 and 2006 c 258 s 6 are each amended to read  
34 as follows:

35 (1) The direct care component rate allocation corresponds to the  
36 provision of nursing care for one resident of a nursing facility for  
37 one day, including direct care supplies. Therapy services and



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

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

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

22 (4) Cost report data used in setting direct care component rate  
23 allocations shall be 1996, 1999, and 2003 for rate periods as specified  
24 in RCW 74.46.431(4)(a).

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

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

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

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

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

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

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

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

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

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

33 (ii) Any facility whose allowable cost per case mix unit is greater  
34 than one hundred fifteen percent of the peer group median established  
35 under (f) of this subsection shall be assigned a cost per case mix unit  
36 equal to one hundred fifteen percent of the peer group median, and  
37 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, for vital local providers, as defined  
24 in this chapter, direct care component rate allocations shall be  
25 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, 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) of this subsection shall be assigned a cost per case mix unit  
9 equal to one hundred twelve percent of the peer group median, and shall  
10 have a direct care component rate allocation equal to the facility's  
11 assigned cost per case mix unit multiplied by that facility's medicaid  
12 average case mix index from the applicable quarter specified in RCW  
13 74.46.501(7)(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) of this subsection shall have a direct care  
17 component rate allocation equal to the facility's allowable cost per  
18 case mix unit multiplied by that facility's medicaid average case mix  
19 index from the applicable quarter specified in RCW 74.46.501(7)(c).

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

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

30 (8) This section expires July 1, 2007.

31 NEW SECTION. **Sec. 15.** A new section is added to chapter 74.46 RCW  
32 to read as follows:

33 (1) Effective July 1, 2007, the department shall establish for each  
34 medicaid nursing facility a direct care one component rate allocation.  
35 The direct care one component rate allocation corresponds to the  
36 provision of nursing care for one resident of a nursing facility for  
37 one day, and includes only costs associated with hours of care provided

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

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

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

20 (4) Cost report data used in setting direct care one component rate  
21 allocations shall be as specified in section 5(2) of this act.

22 (5) The department shall rebase each nursing facility's direct care  
23 one component rate allocation biennially as specified in section 5(2)  
24 of this act, adjust its direct care one component rate allocation for  
25 economic trends and conditions as described in section 5(3) of this  
26 act, and update its medicaid average case mix index, consistent with  
27 the following:

28 (a) Reduce total direct care one costs reported by each nursing  
29 facility for the applicable cost report period specified in section  
30 5(2) of this act to reflect any department adjustments, in order to  
31 derive the facility's total allowable direct care one cost;

32 (b) Divide each facility's total allowable direct care one cost by  
33 its adjusted resident days for the same report period;

34 (c) Adjust the facility's per resident day direct care one cost by  
35 the economic trends and conditions factor established under section  
36 5(2) of this act to derive its adjusted allowable direct care cost per  
37 resident day;

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

5 (e) Divide nursing facilities into at least two and, if applicable,  
6 three peer groups: (i) Those located in nonurban counties; (ii) those  
7 located in high labor-cost counties, if any; and (iii) those located in  
8 other urban counties;

9 (f) Array separately the allowable direct care one cost per case  
10 mix unit for all facilities in nonurban counties; for all facilities in  
11 high labor-cost counties, if applicable; and for all facilities in  
12 other urban counties, and determine the median allowable direct care  
13 cost per case mix unit for each peer group;

14 (g) Determine each facility's quarterly direct care one component  
15 rate as follows:

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

24 (ii) Any facility whose allowable cost per case mix unit is less  
25 than or equal to one hundred twelve percent of the peer group median  
26 established under (f) of this subsection shall have a direct care one  
27 component rate allocation equal to the facility's allowable cost per  
28 case mix unit multiplied by that facility's medicaid average case mix  
29 index from the applicable quarter specified in RCW 74.46.501(7)(c).

30 (6) The direct care one component rate allocations calculated in  
31 accordance with this section shall be adjusted to the extent necessary  
32 to comply with RCW 74.46.421.

33 (7) Costs related to payments resulting from increases in direct  
34 care one component rates, granted under authority of RCW 74.46.508(1)  
35 for a facility's exceptional care residents or section 16 of this act,  
36 shall be offset against the facility's examined, allowable direct care  
37 one costs, for each report year or partial period such increases are

1 paid. Such reductions in allowable direct care one costs shall be for  
2 rate setting, settlement, and other purposes deemed appropriate by the  
3 department.

4 NEW SECTION. **Sec. 16.** A new section is added to chapter 74.46 RCW  
5 to read as follows:

6 (1) The department shall grant an add-on to the direct care one  
7 component rate allocation for nursing facilities meeting the following  
8 criteria:

9 (a) For the July 1, 2007, rate setting, the nursing facility's  
10 direct care one cost per case mix unit, as established in section 15 of  
11 this act, is less than one hundred twelve percent of the median cost  
12 per case mix unit for that facility's direct care one peer group; and

13 (b) The nursing facility's medicaid census was sixty percent or  
14 greater in calendar year 2005.

15 (2) The amount of the add-on shall be calculated in the following  
16 manner:

17 (a) Determine the difference between the facility's direct care one  
18 cost per case mix unit and the cost per case mix unit set at one  
19 hundred twelve percent of the median for that facility's direct care  
20 one peer group, as of the July 1, 2007, rate setting; and

21 (b) Multiply the difference determined in (a) of this subsection by  
22 the facility's medicaid case mix score as of July 1, 2007; and

23 (c) Multiply the product determined in (b) of this subsection by  
24 fifty percent; and

25 (d) Multiply the product determined in (c) of this subsection by  
26 the facility's medicaid census for the calendar year 2005.

27 (3) The amount of the add-on granted in this section shall be added  
28 to the facility's direct care one rate, and the direct care one rate  
29 including the add-on shall be subject to the settlement process  
30 established in section 3 of this act.

31 (4) This section expires July 1, 2011.

32 **Sec. 17.** RCW 74.46.508 and 2003 1st sp.s. c 6 s 1 are each amended  
33 to read as follows:

34 (1) The department is authorized to increase the direct care one  
35 and direct care two component rate allocations calculated under ((RCW  
36 ~~74.46.506(5)~~) this chapter for residents who have unmet exceptional



1 care needs as determined by the department in rule. The department  
2 may, by rule, establish criteria, patient categories, and methods of  
3 exceptional care payment.

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

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

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

14 **Sec. 18.** RCW 74.46.511 and 2001 1st sp.s. c 8 s 11 are each  
15 amended to read as follows:

16 (1) The therapy care component rate allocation corresponds to the  
17 provision of medicaid one-on-one therapy provided by a qualified  
18 therapist as defined in this chapter, including therapy supplies and  
19 therapy consultation, for one day for one medicaid resident of a  
20 nursing facility. The therapy care component rate allocation for  
21 October 1, 1998, through June 30, 2001, shall be based on adjusted  
22 therapy costs and days from calendar year 1996. The therapy component  
23 rate allocation for July 1, 2001, through June 30, 2004, shall be based  
24 on adjusted therapy costs and days from calendar year 1999. The  
25 therapy care component rate shall be adjusted for economic trends and  
26 conditions as specified in RCW 74.46.431(5)(b), and shall be determined  
27 in accordance with this section.

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

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

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

37 (c) Therapy consulting expenses for all residents.

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

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

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

8 (b) Those located within nonurban counties.

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

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

19 (a) To determine the allowable total therapy cost for each therapy  
20 type, the allowable cost per unit of therapy for each type of therapy  
21 shall be multiplied by the total therapy units for each type of  
22 therapy;

23 (b) The medicaid allowable one-on-one therapy expense shall be  
24 calculated taking the allowable total therapy cost for each therapy  
25 type times the medicaid percent of total therapy charges for each  
26 therapy type;

27 (c) The medicaid allowable one-on-one therapy expense for each  
28 therapy type shall be divided by total adjusted medicaid days to arrive  
29 at the medicaid one-on-one therapy cost per patient day for each  
30 therapy type;

31 (d) The medicaid one-on-one therapy cost per patient day for each  
32 therapy type shall be multiplied by total adjusted patient days for all  
33 residents to calculate the total allowable one-on-one therapy expense.  
34 The lesser of the total allowable therapy consultant expense for the  
35 therapy type or a reasonable percentage of allowable therapy consultant  
36 expense for each therapy type, as established in rule by the  
37 department, shall be added to the total allowable one-on-one therapy  
38 expense to determine the allowable therapy cost for each therapy type;

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

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

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

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

16 (8) This section expires July 1, 2007.

17 **Sec. 19.** RCW 74.46.515 and 2001 1st sp.s. c 8 s 12 are each  
18 amended to read as follows:

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

22 (2) Beginning October 1, 1998, the department shall determine each  
23 medicaid nursing facility's support services component rate allocation  
24 using cost report data specified by RCW 74.46.431(6).

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

27 (a) Array facilities' adjusted support services costs per adjusted  
28 resident day for each facility from facilities' cost reports from the  
29 applicable report year, for facilities located within urban counties,  
30 and for those located within nonurban counties and determine the median  
31 adjusted cost for each peer group;

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

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

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

6 (5) This section expires July 1, 2007.

7 NEW SECTION. **Sec. 20.** A new section is added to chapter 74.46 RCW  
8 to read as follows:

9 (1) Effective July 1, 2007, the department shall establish for each  
10 medicaid nursing facility a direct care two component rate allocation.  
11 The direct care two component rate allocation corresponds to the  
12 provision of food, food preparation, dietary, housekeeping, laundry  
13 services, therapy, and nursing-related services not included in direct  
14 care one for one resident for one day. For the direct care two  
15 component rate allocation, therapy corresponds to the provision of  
16 medicaid one-on-one therapy provided by a qualified therapist as  
17 defined in this chapter, including therapy supplies and therapy  
18 consultation.

19 (2) The department shall determine each medicaid nursing facility's  
20 direct care two component rate allocation using cost report data as  
21 specified in section 5 of this act.

22 (3) To determine each facility's direct care two component rate  
23 allocation, the department shall:

24 (a) Array facilities' adjusted direct care two costs per adjusted  
25 resident day for each facility from facilities' cost reports from the  
26 applicable report year, for facilities located within urban counties,  
27 for those located within nonurban counties, and for those located in  
28 high labor-cost counties, if any, and determine the median adjusted  
29 cost per adjusted resident day for each peer group;

30 (b) Set each facility's direct care two component rate at the lower  
31 of the facility's per resident day adjusted direct care two costs from  
32 the applicable cost report period or the adjusted median per resident  
33 day direct care two cost for that facility's peer group, either urban  
34 counties or nonurban counties, plus twelve percent; and

35 (c) Adjust each facility's direct care two component rate for  
36 economic trends and conditions as provided in section 5 of this act.

1 (4) The direct care two component rate allocations calculated in  
2 accordance with this section shall be adjusted to the extent necessary  
3 to comply with RCW 74.46.421.

4 NEW SECTION. **Sec. 21.** A new section is added to chapter 74.46 RCW  
5 to read as follows:

6 (1) The department shall grant an add-on to the direct care two  
7 component rate allocation for nursing facilities meeting the following  
8 criteria:

9 (a) For the July 1, 2007, rate setting, the nursing facility's  
10 direct care two costs per resident day, as established in this chapter,  
11 are less than one hundred twelve percent of the median costs per  
12 resident day for that facility's direct care two peer group; and

13 (b) The nursing facility's medicaid census was sixty percent or  
14 greater in calendar year 2005.

15 (2) The amount of the add-on shall be calculated in the following  
16 manner:

17 (a) Determine the difference between the facility's July 1, 2007,  
18 direct care two costs per resident day and the costs per resident day  
19 set at one hundred twelve percent of the median for that facility's  
20 direct care two peer group, as of the July 1, 2007, rate setting; and

21 (b) Multiply the product determined in (a) of this subsection by  
22 fifty percent; and

23 (c) Multiply the product determined in (b) of this subsection by  
24 the facility's medicaid census for the calendar year 2005.

25 (3) The amount of the add-on granted in this section shall be added  
26 to the facility's direct care two rate, and the direct care two rate  
27 including the add-on shall be subject to the settlement process  
28 established in section 3 of this act.

29 (4) This section expires July 1, 2011.

30 **Sec. 22.** RCW 74.46.521 and 2006 c 258 s 7 are each amended to read  
31 as follows:

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

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

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

12 (3) Except as provided in subsection (4) of this section, to  
13 determine each facility's operations component rate the department  
14 shall:

15 (a) Array facilities' adjusted general operations costs per  
16 adjusted resident day, as determined by dividing each facility's total  
17 allowable operations cost by its adjusted resident days for the same  
18 report period, increased if necessary to a minimum occupancy of ninety  
19 percent; that is, the greater of actual or imputed occupancy at ninety  
20 percent of licensed beds, for each facility from facilities' cost  
21 reports from the applicable report year, for facilities located within  
22 urban counties and for those located within nonurban counties and  
23 determine the median adjusted cost for each peer group;

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

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

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

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

34 (4)(a) Effective July 1, 2006, for any facility whose direct care  
35 component rate allocation is set equal to its June 30, 2006, direct  
36 care component rate allocation, as provided in RCW 74.46.506(5)(i), the  
37 facility's operations component rate allocation shall also be set equal  
38 to the facility's June 30, 2006, operations component rate allocation.

1 (b) The operations component rate allocation for facilities whose  
2 operations component rate is set equal to their June 30, 2006,  
3 operations component rate, shall be adjusted for economic trends and  
4 conditions as provided in RCW 74.46.431(7)(b).

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

8 (6) This section expires July 1, 2007.

9 NEW SECTION. **Sec. 23.** A new section is added to chapter 74.46 RCW  
10 to read as follows:

11 (1) Effective July 1, 2007, the department shall establish for each  
12 medicaid nursing facility an operations component rate allocation. The  
13 operations component rate allocation corresponds to the general  
14 operation of a nursing facility for one resident for one day, including  
15 but not limited to management, administration, utilities, office  
16 supplies, accounting and bookkeeping, minor building maintenance, minor  
17 equipment repairs and replacements, and other supplies and services,  
18 exclusive of direct care one, direct care two, and capital. The  
19 operations component rate allocation does not include the costs of the  
20 quality maintenance fee established under RCW 82.71.020, nor shall such  
21 costs be included in any of the component rate allocations under this  
22 chapter.

23 (2) The department shall determine each medicaid nursing facility's  
24 operations component rate allocation using cost report data specified  
25 in section 5 of this act.

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

28 (a) Array facilities' adjusted general operations costs per  
29 adjusted resident day, for each facility from facilities' cost reports  
30 from the applicable report year, for facilities located within urban  
31 counties and for those located within nonurban counties, and for those  
32 located in high labor-cost counties, if any, and determine the median  
33 adjusted cost for each peer group;

34 (b) Set each facility's operations component rate at the lower of  
35 the facility's per resident day adjusted operations costs from the  
36 applicable cost report period or the adjusted median per resident day

1 support services cost for that facility's peer group, either urban or  
2 nonurban counties, or high labor-cost counties, plus seven percent; and

3 (c) Adjust each facility's operations component rate for economic  
4 trends and conditions as provided in section 5 of this act.

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

8 NEW SECTION. **Sec. 24.** Except for section 2 of this act, this act  
9 is necessary for the immediate preservation of the public peace,  
10 health, or safety, or support of the state government and its existing  
11 public institutions, and takes effect July 1, 2007.

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