

CERTIFICATION OF ENROLLMENT

**ENGROSSED SUBSTITUTE SENATE BILL 5581**

Chapter 7, Laws of 2011

62nd Legislature  
2011 1st Special Session

NURSING HOMES

EFFECTIVE DATE: 07/01/11

Passed by the Senate May 11, 2011  
YEAS 27 NAYS 17

BRAD OWEN

\_\_\_\_\_  
**President of the Senate**

Passed by the House May 17, 2011  
YEAS 54 NAYS 38

FRANK CHOPP

\_\_\_\_\_  
**Speaker of the House of Representatives**

Approved May 31, 2011, 2:22 p.m.

CHRISTINE GREGOIRE

\_\_\_\_\_  
**Governor of the State of Washington**

CERTIFICATE

I, Thomas Hoemann, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **ENGROSSED SUBSTITUTE SENATE BILL 5581** as passed by the Senate and the House of Representatives on the dates hereon set forth.

THOMAS HOEMANN

\_\_\_\_\_  
**Secretary**

FILED

June 1, 2011

**Secretary of State  
State of Washington**

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**ENGROSSED SUBSTITUTE SENATE BILL 5581**

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Passed Legislature - 2011 1st Special Session

**State of Washington                      62nd Legislature                      2011 1st Special Session**

**By** Senate Ways & Means (originally sponsored by Senators Keiser, Parlette, Hargrove, Shin, Conway, and Kline)

READ FIRST TIME 04/01/11.

1            AN ACT Relating to nursing homes; amending RCW 74.46.431,  
2 74.46.435, 74.46.437, 74.46.485, 74.46.496, 74.46.501, 74.46.506,  
3 74.46.515, and 74.46.521; reenacting and amending RCW 43.84.092; adding  
4 a new section to chapter 74.46 RCW; adding a new chapter to Title 74  
5 RCW; creating a new section; repealing RCW 74.46.433; prescribing  
6 penalties; providing an effective date; and declaring an emergency.

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

8            **Sec. 1.** RCW 74.46.431 and 2010 1st sp.s. c 34 s 3 are each amended  
9 to read as follows:

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

17            (2) Component rate allocations in therapy care and support services  
18 for all facilities shall be based upon a minimum facility occupancy of  
19 eighty-five percent of licensed beds, regardless of how many beds are

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

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

35 (4)(a) Direct care component rate allocations shall be established  
36 using adjusted cost report data covering at least six months.  
37 Effective July 1, 2009, the direct care component rate allocation shall  
38 be rebased, (~~using the adjusted cost report data for the calendar year~~

1 ~~two-years-immediately-preceding-the-rate-rebase-period,~~) so that  
2 adjusted cost report data for calendar year 2007 is used for July 1,  
3 2009, through June 30, ~~((2012))~~ 2013. Beginning July 1, ~~((2012))~~ 2013,  
4 the direct care component rate allocation shall be rebased biennially  
5 during every ~~((even-numbered))~~ odd-numbered year thereafter using  
6 adjusted cost report data from two years prior to the rebase period, so  
7 adjusted cost report data for calendar year ~~((2010))~~ 2011 is used for  
8 July 1, ~~((2012))~~ 2013, through June 30, ~~((2014))~~ 2015, and so forth.

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

23 (5)(a) Therapy care component rate allocations shall be established  
24 using adjusted cost report data covering at least six months.  
25 Effective July 1, 2009, the therapy care component rate allocation  
26 shall be cost rebased, so that adjusted cost report data for calendar  
27 year 2007 is used for July 1, 2009, through June 30, ~~((2012))~~ 2013.  
28 Beginning July 1, ~~((2012))~~ 2013, the therapy care component rate  
29 allocation shall be rebased biennially during every ~~((even-numbered))~~  
30 odd-numbered year thereafter using adjusted cost report data from two  
31 years prior to the rebase period, so adjusted cost report data for  
32 calendar year ~~((2010))~~ 2011 is used for July 1, ~~((2012))~~ 2013, through  
33 June 30, ~~((2014))~~ 2015, and so forth.

34 (b) Therapy care component rate allocations established in  
35 accordance with this chapter shall be adjusted annually for economic  
36 trends and conditions by a factor or factors defined in the biennial  
37 appropriations act. The economic trends and conditions factor or  
38 factors defined in the biennial appropriations act shall not be

1 compounded with the economic trends and conditions factor or factors  
2 defined in any other biennial appropriations acts before applying it to  
3 the therapy care component rate allocation established in accordance  
4 with this chapter. When no economic trends and conditions factor or  
5 factors for either fiscal year are defined in a biennial appropriations  
6 act, no economic trends and conditions factor or factors defined in any  
7 earlier biennial appropriations act shall be applied solely or  
8 compounded to the therapy care component rate allocation established in  
9 accordance with this chapter.

10 (6)(a) Support services component rate allocations shall be  
11 established using adjusted cost report data covering at least six  
12 months. Effective July 1, 2009, the support services component rate  
13 allocation shall be cost rebased, so that adjusted cost report data for  
14 calendar year 2007 is used for July 1, 2009, through June 30, (~~2012~~)  
15 2013. Beginning July 1, (~~2012~~) 2013, the support services component  
16 rate allocation shall be rebased biennially during every (~~even-~~  
17 ~~numbered~~) odd-numbered year thereafter using adjusted cost report data  
18 from two years prior to the rebase period, so adjusted cost report data  
19 for calendar year (~~2010~~) 2011 is used for July 1, (~~2012~~) 2013,  
20 through June 30, (~~2014~~) 2015, and so forth.

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

35 (7)(a) Operations component rate allocations shall be established  
36 using adjusted cost report data covering at least six months.  
37 Effective July 1, 2009, the operations component rate allocation shall  
38 be cost rebased, so that adjusted cost report data for calendar year

1 2007 is used for July 1, 2009, through June 30, (~~(2012))~~ 2013.  
2 Beginning July 1, (~~(2012))~~ 2013, the operations care component rate  
3 allocation shall be rebased biennially during every (~~even-numbered~~)  
4 odd-numbered year thereafter using adjusted cost report data from two  
5 years prior to the rebase period, so adjusted cost report data for  
6 calendar year (~~(2010))~~ 2011 is used for July 1, (~~(2012))~~ 2013, through  
7 June 30, (~~(2014))~~ 2015, and so forth.

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

22 (8) 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 (9) The department shall establish in rule procedures, principles,  
26 and conditions for determining component rate allocations for  
27 facilities in circumstances not directly addressed by this chapter,  
28 including but not limited to: Inflation adjustments for partial-period  
29 cost report data, newly constructed facilities, existing facilities  
30 entering the medicaid program for the first time or after a period of  
31 absence from the program, existing facilities with expanded new bed  
32 capacity, existing medicaid facilities following a change of ownership  
33 of the nursing facility business, facilities temporarily reducing the  
34 number of set-up beds during a remodel, facilities having less than six  
35 months of either resident assessment, cost report data, or both, under  
36 the current contractor prior to rate setting, and other circumstances.

37 (10) The department shall establish in rule procedures, principles,  
38 and conditions, including necessary threshold costs, for adjusting

1 rates to reflect capital improvements or new requirements imposed by  
2 the department or the federal government. Any such rate adjustments  
3 are subject to the provisions of RCW 74.46.421.

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

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

16 **Sec. 2.** RCW 74.46.435 and 2010 1st sp.s. c 34 s 5 are each amended  
17 to read as follows:

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

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

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

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

3 (4) The property 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 **Sec. 3.** RCW 74.46.437 and 2001 1st sp.s. c 8 s 8 are each amended  
7 to read as follows:

8 (1) (~~Beginning July 1, 1999,~~) The department shall establish for  
9 each medicaid nursing facility a financing allowance component rate  
10 allocation. The financing allowance component rate shall be rebased  
11 annually, effective July 1st, in accordance with the provisions of this  
12 section and this chapter.

13 (2) (~~Effective July 1, 2001,~~) The financing allowance (~~shall~~  
14 ~~be~~) is determined by multiplying the net invested funds of each  
15 facility by (~~.10~~) .04, and dividing by the greater of a nursing  
16 facility's total resident days from the most recent cost report period  
17 or resident days calculated on (~~eighty-five~~) eighty-seven percent  
18 facility occupancy(~~. Effective July 1, 2002, the financing allowance~~  
19 ~~component rate allocation for all facilities, other than essential~~  
20 ~~community providers, shall be set by using the greater of a facility's~~  
21 ~~total resident days from the most recent cost report period or resident~~  
22 ~~days calculated at ninety percent facility occupancy. However, assets~~  
23 ~~acquired on or after May 17, 1999, shall be grouped in a separate~~  
24 ~~financing allowance calculation that shall be multiplied by .085. The~~  
25 ~~financing allowance factor of .085 shall not be applied to the net~~  
26 ~~invested funds pertaining to new construction or major renovations~~  
27 ~~receiving certificate of need approval or an exemption from certificate~~  
28 ~~of need requirements under chapter 70.38 RCW, or to working drawings~~  
29 ~~that have been submitted to the department of health for construction~~  
30 ~~review approval, prior to May 17, 1999)) for essential community  
31 providers, ninety-two percent facility occupancy for small nonessential  
32 community providers, or ninety-five percent occupancy for large  
33 nonessential community providers. If a capitalized addition,  
34 renovation, replacement, or retirement of an asset will result in a  
35 different licensed bed capacity during the ensuing period, the prior  
36 period total resident days used in computing the financing allowance  
37 shall be adjusted to the greater of the anticipated resident day level~~



1 or (~~eighty-five~~) eighty-seven percent of the new licensed bed  
2 capacity for essential community providers, ninety-two percent facility  
3 occupancy for small nonessential community providers, or ninety-five  
4 percent occupancy for large nonessential community providers.  
5 (~~Effective July 1, 2002, for all facilities, other than essential~~  
6 ~~community providers, the total resident days used to compute the~~  
7 ~~financing allowance after a capitalized addition, renovation,~~  
8 ~~replacement, or retirement of an asset shall be set by using the~~  
9 ~~greater of a facility's total resident days from the most recent cost~~  
10 ~~report period or resident days calculated at ninety percent facility~~  
11 ~~occupancy.))~~

12 (3) In computing the portion of net invested funds representing the  
13 net book value of tangible fixed assets, the same assets, depreciation  
14 bases, lives, and methods referred to in (~~RCW 74.46.330, 74.46.350,~~  
15 ~~74.46.360, 74.46.370, and 74.46.380~~) department rule, including owned  
16 and leased assets, shall be utilized, except that the capitalized cost  
17 of land upon which the facility is located and such other contiguous  
18 land which is reasonable and necessary for use in the regular course of  
19 providing resident care (~~shall~~) must also be included. Subject to  
20 provisions and limitations contained in this chapter, for land  
21 purchased by owners or lessors before July 18, 1984, capitalized cost  
22 of land (~~shall be~~) is the buyer's capitalized cost. For all partial  
23 or whole rate periods after July 17, 1984, if the land is purchased  
24 after July 17, 1984, capitalized cost (~~shall be~~) is that of the owner  
25 of record on July 17, 1984, or buyer's capitalized cost, whichever is  
26 lower. In the case of leased facilities where the net invested funds  
27 are unknown or the contractor is unable to provide necessary  
28 information to determine net invested funds, the secretary (~~shall~~  
29 ~~have~~) has the authority to determine an amount for net invested funds  
30 based on an appraisal conducted according to (~~RCW 74.46.360(1)~~)  
31 department rule.

32 (4) (~~Effective July 1, 2001, for the purpose of calculating a~~  
33 ~~nursing facility's financing allowance component rate, if a contractor~~  
34 ~~has elected to bank licensed beds prior to May 25, 2001, or elects to~~  
35 ~~convert banked beds to active service at any time, under chapter 70.38~~  
36 ~~RCW, the department shall use the facility's new licensed bed capacity~~  
37 ~~to recalculate minimum occupancy for rate setting and revise the~~  
38 ~~financing allowance component rate, as needed, effective as of the date~~

1 ~~the beds are banked or converted to active service. However, in no~~  
2 ~~case shall the department use less than eighty five percent occupancy~~  
3 ~~of the facility's licensed bed capacity after banking or conversion.~~  
4 ~~Effective July 1, 2002, in no case, other than for essential community~~  
5 ~~providers, shall the department use less than ninety percent occupancy~~  
6 ~~of the facility's licensed bed capacity after conversion.~~

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

10 **Sec. 4.** RCW 74.46.485 and 2010 1st sp.s. c 34 s 9 are each amended  
11 to read as follows:

12 (1) The department shall:

13 (a) Employ the resource utilization group III case mix  
14 classification methodology. The department shall use the forty-four  
15 group index maximizing model for the resource utilization group III  
16 grouper version 5.10, but the department may revise or update the  
17 classification methodology to reflect advances or refinements in  
18 resident assessment or classification, subject to federal requirements.  
19 The department may adjust the case mix index for any of the lowest ten  
20 resource utilization group categories beginning with PA1 through PE2 to  
21 any case mix index that aids in achieving the purpose and intent of RCW  
22 74.39A.007 and cost-efficient care; and

23 (b) Implement minimum data set 3.0 under the authority of this  
24 section and RCW 74.46.431(3). The department must notify nursing home  
25 contractors twenty-eight days in advance the date of implementation of  
26 the minimum data set 3.0. In the notification, the department must  
27 identify for all semiannual rate settings following the date of minimum  
28 data set 3.0 implementation a previously established semiannual case  
29 mix adjustment established for the semiannual rate settings that will  
30 be used for semiannual case mix calculations in direct care until  
31 minimum data set 3.0 is fully implemented. (~~After the department has~~  
32 ~~fully implemented minimum data set 3.0, it must adjust any semiannual~~  
33 ~~rate setting in which it used the previously established case mix~~  
34 ~~adjustment using the new minimum data set 3.0 data.))~~

35 (2) A default case mix group shall be established for cases in  
36 which the resident dies or is discharged for any purpose prior to

1 completion of the resident's initial assessment. The default case mix  
2 group and case mix weight for these cases shall be designated by the  
3 department.

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

8 **Sec. 5.** RCW 74.46.496 and 2010 1st sp.s. c 34 s 10 are each  
9 amended to read as follows:

10 (1) Each case mix classification group shall be assigned a case mix  
11 weight. The case mix weight for each resident of a nursing facility  
12 for each calendar quarter or six-month period during a calendar year  
13 shall be based on data from resident assessment instruments completed  
14 for the resident and weighted by the number of days the resident was in  
15 each case mix classification group. Days shall be counted as provided  
16 in this section.

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

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

28 (a) Set the certified nurse aide wage weight at 1.000 and calculate  
29 wage weights for registered nurse and licensed practical nurse average  
30 wages by dividing the certified nurse aide average wage into the  
31 registered nurse average wage and licensed practical nurse average  
32 wage;

33 (b) Calculate the total weighted minutes for each case mix group in  
34 the resource utilization group ((~~HH~~)) classification system by  
35 multiplying the wage weight for each worker classification by the  
36 average number of minutes that classification of worker spends caring

1 for a resident in that resource utilization group ((~~III~~))  
2 classification group, and summing the products;

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

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

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

20 **Sec. 6.** RCW 74.46.501 and 2010 1st sp.s. c 34 s 11 are each  
21 amended to read as follows:

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

27 (2)(a) In calculating a facility's two average case mix indexes for  
28 each quarter, the department shall include all residents or medicaid  
29 residents, as applicable, who were physically in the facility during  
30 the quarter in question based on the resident assessment instrument  
31 completed by the facility and the requirements and limitations for the  
32 instrument's completion and transmission (January 1st through March  
33 31st, April 1st through June 30th, July 1st through September 30th, or  
34 October 1st through December 31st).

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

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

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

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

15 (6)(a) Although the facility average and the medicaid average case  
16 mix indexes shall both be calculated quarterly, the cost-rebasing  
17 period facility average case mix index will be used throughout the  
18 applicable cost-rebasing period in combination with cost report data as  
19 specified by RCW 74.46.431 and 74.46.506, to establish a facility's  
20 allowable cost per case mix unit. To allow for the transition to  
21 minimum data set 3.0 and implementation of resource utilization group  
22 IV for July 1, 2011, through June 30, 2013, the department shall  
23 calculate rates using the medicaid average case mix scores effective  
24 for January 1, 2011, rates adjusted under RCW 74.46.485(1)(a), and the  
25 scores shall be increased each six months during the transition period  
26 by one-half of one percent. The July 1, 2013, direct care cost per  
27 case mix unit shall be calculated by utilizing 2011 direct care costs,  
28 patient days, and 2011 facility average case mix indexes based on the  
29 minimum data set 3.0 resource utilization group IV grouper 57. A  
30 facility's medicaid average case mix index shall be used to update a  
31 nursing facility's direct care component rate semiannually.

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

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

8 **Sec. 7.** RCW 74.46.506 and 2010 1st sp.s. c 34 s 12 are each  
9 amended to read as follows:

10 (1) The direct care component rate allocation corresponds to the  
11 provision of nursing care for one resident of a nursing facility for  
12 one day, including direct care supplies. Therapy services and  
13 supplies, which correspond to the therapy care component rate, shall be  
14 excluded. The direct care component rate includes elements of case mix  
15 determined consistent with the principles of this section and other  
16 applicable provisions of this chapter.

17 (2) The department shall determine and update semiannually for each  
18 nursing facility serving medicaid residents a facility-specific per-  
19 resident day direct care component rate allocation, to be effective on  
20 the first day of each six-month period. In determining direct care  
21 component rates the department shall utilize, as specified in this  
22 section, minimum data set resident assessment data for each resident of  
23 the facility, as transmitted to, and if necessary corrected by, the  
24 department in the resident assessment instrument format approved by  
25 federal authorities for use in this state.

26 (3) The department may question the accuracy of assessment data for  
27 any resident and utilize corrected or substitute information, however  
28 derived, in determining direct care component rates. The department is  
29 authorized to impose civil fines and to take adverse rate actions  
30 against a contractor, as specified by the department in rule, in order  
31 to obtain compliance with resident assessment and data transmission  
32 requirements and to ensure accuracy.

33 (4) Cost report data used in setting direct care component rate  
34 allocations shall be for rate periods as specified in RCW  
35 74.46.431(4)(a).

36 (5) The department shall rebase each nursing facility's direct care  
37 component rate allocation as described in RCW 74.46.431, adjust its

1 direct care component rate allocation for economic trends and  
2 conditions as described in RCW 74.46.431, and update its medicaid  
3 average case mix index as described in RCW 74.46.496 and 74.46.501,  
4 consistent with the following:

5 (a) Adjust total direct care costs reported by each nursing  
6 facility for the applicable cost report period specified in RCW  
7 74.46.431(4)(a) to reflect any department adjustments, and to eliminate  
8 reported resident therapy costs and adjustments, in order to derive the  
9 facility's total allowable direct care cost;

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

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

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

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

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

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

36 (ii) Any facility whose allowable cost per case mix unit is less  
37 than or equal to one hundred (~~((twelve))~~) ten percent of the peer group  
38 median established under (e) of this subsection shall have a direct

1 care component rate allocation equal to the facility's allowable cost  
2 per case mix unit multiplied by that facility's medicaid average case  
3 mix index from the applicable six-month period specified in RCW  
4 74.46.501(6)(c).

5 (6) The direct care 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 (7) Costs related to payments resulting from increases in direct  
9 care component rates, granted under authority of RCW 74.46.508 for a  
10 facility's exceptional care residents, shall be offset against the  
11 facility's examined, allowable direct care costs, for each report year  
12 or partial period such increases are paid. Such reductions in  
13 allowable direct care costs shall be for rate setting, settlement, and  
14 other purposes deemed appropriate by the department.

15 **Sec. 8.** RCW 74.46.515 and 2010 1st sp.s. c 34 s 15 are each  
16 amended to read as follows:

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

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

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

25 (a) Array facilities' adjusted support services costs per adjusted  
26 resident day, as determined by dividing each facility's total allowable  
27 support services costs by its adjusted resident days for the same  
28 report period, increased if necessary to a minimum occupancy provided  
29 by RCW 74.46.431(2), 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 determine  
32 the median adjusted cost for each peer group;

33 (b) Set each facility's support services component rate at the  
34 lower of the facility's per resident day adjusted support services  
35 costs from the applicable cost report period or the adjusted median per  
36 resident day support services cost for that facility's peer group,



1 either urban counties or nonurban counties, plus (~~ten~~) eight percent;  
2 and

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

5 (4) The support services 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 **Sec. 9.** RCW 74.46.521 and 2010 1st sp.s. c 34 s 16 are each  
9 amended to read as follows:

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

17 (2) The department shall determine each medicaid nursing facility's  
18 operations component rate allocation using cost report data specified  
19 by RCW 74.46.431(7)(a). Operations component rates for essential  
20 community providers shall be based upon a minimum occupancy of  
21 (~~eighty-five~~) eighty-seven percent of licensed beds. Operations  
22 component rates for small nonessential community providers shall be  
23 based upon a minimum occupancy of (~~ninety~~) ninety-two percent of  
24 licensed beds. Operations component rates for large nonessential  
25 community providers shall be based upon a minimum occupancy of  
26 (~~ninety-two~~) ninety-five percent of licensed beds.

27 (3) For all calculations and adjustments in this subsection, the  
28 department shall use the greater of the facility's actual occupancy or  
29 an (~~imputed~~) occupancy equal to (~~eighty-five~~) eighty-seven percent  
30 for essential community providers, (~~ninety~~) ninety-two percent for  
31 small nonessential community providers, or (~~ninety-two~~) ninety-five  
32 percent for large nonessential community providers. To determine each  
33 facility's operations component rate the department shall:

34 (a) Array facilities' adjusted general operations costs per  
35 adjusted resident day, as determined by dividing each facility's total  
36 allowable operations cost by its adjusted resident days for the same

1 report period for facilities located within urban counties and for  
2 those located within nonurban counties and determine the median  
3 adjusted cost for each peer group;

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

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

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

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

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

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

18 (1) The department shall establish a skilled nursing facility  
19 safety net assessment medicaid share pass through or rate add-on to  
20 reimburse the medicaid share of the skilled nursing facility safety net  
21 assessment as a medicaid allowable cost consistent with section 15 of  
22 this act. This add-on shall not be considered an allowable cost for  
23 future year cost rebasing.

24 (2) As of the effective date of this section, supplemental payments  
25 to reimburse medicaid expenditures, including an amount to reimburse  
26 the medicaid share of the skilled nursing facility safety net  
27 assessment, not to exceed the annual medicare upper payment limit, must  
28 be provided for all years when the skilled nursing facility safety net  
29 assessment is levied, consistent with section 15 of this act. These  
30 supplemental payments, at a minimum, must be sufficient to reimburse  
31 the medicaid share of the assessment for those paying the assessment.  
32 The part of these supplemental payments that reimburses the medicaid  
33 share of the assessment are not subject to the reconciliation and  
34 settlement process provided in RCW 74.46.022(6).

35 NEW SECTION. **Sec. 11.** (1) For fiscal years 2012 and 2013 and  
36 subject to appropriation, the department of social and health services

1 shall do a comparative analysis of the facility-based payment rates  
2 calculated on July 1, 2011, using the payment methodology defined in  
3 chapter 74.46 RCW as modified by sections 1 through 9 of this act, to  
4 the facility-based payment rates in effect June 30, 2010. If the  
5 facility-based payment rate calculated on July 1, 2011, is smaller than  
6 the facility-based payment rate on June 30, 2011, the difference shall  
7 be provided to the individual nursing facilities as an add-on payment  
8 per medicaid resident day.

9 (2) During the comparative analysis performed in subsection (1) of  
10 this section, if it is found that the direct care rate for any facility  
11 calculated under sections 1 through 9 of this act is greater than the  
12 direct care rate in effect on June 30, 2010, then the facility shall  
13 receive a ten percent direct care rate add-on to compensate that  
14 facility for taking on more acute clients than they have in the past.

15 (3) The rate add-ons provided in subsection (2) of this section are  
16 subject to the reconciliation and settlement process provided in RCW  
17 74.46.022(6).

18 NEW SECTION. **Sec. 12.** PURPOSE, FINDINGS, AND INTENT. (1) It is  
19 the intent of the legislature to encourage maximization of financial  
20 resources eligible and available for medicaid services by establishing  
21 the skilled nursing facility safety net trust fund to receive skilled  
22 nursing facility safety net assessments to use in securing federal  
23 matching funds under federally prescribed programs available through  
24 the state medicaid plan.

25 (2) The purpose of this chapter is to provide for a safety net  
26 assessment on certain Washington skilled nursing facilities, which will  
27 be used solely to support payments to skilled nursing facilities for  
28 medicaid services.

29 (3) The legislature finds that:

30 (a) Washington skilled nursing facilities have proposed a skilled  
31 nursing facility safety net assessment to generate additional state and  
32 federal funding for the medicaid program, which will be used in part to  
33 restore recent reductions in skilled nursing facility reimbursement  
34 rates and provide for an increase in medicaid reimbursement rates; and

35 (b) The skilled nursing facility safety net assessment and skilled  
36 nursing facility safety net trust fund created in this chapter allows

1 the state to generate additional federal financial participation for  
2 the medicaid program and provides for increased reimbursement to  
3 skilled nursing facilities.

4 (4) In adopting this chapter, it is the intent of the legislature:

5 (a) To impose a skilled nursing facility safety net assessment to  
6 be used solely for the purposes specified in this chapter;

7 (b) That funds generated by the assessment, including matching  
8 federal financial participation, shall not be used for purposes other  
9 than as specified in this chapter;

10 (c) That the total amount assessed not exceed the amount needed, in  
11 combination with all other available funds, to support the  
12 reimbursement rates and other payments authorized by this chapter,  
13 including payments under section 15 of this act; and

14 (d) To condition the assessment and use of the resulting funds on  
15 receiving federal approval for receipt of additional federal financial  
16 participation.

17 NEW SECTION. **Sec. 13.** DEFINITIONS. The definitions in this  
18 section apply throughout this chapter unless the context clearly  
19 requires otherwise.

20 (1) "Certain high volume medicaid nursing facilities" means the  
21 fewest number of facilities necessary with the highest number of  
22 medicaid days or total patient days annually to meet the statistical  
23 redistribution test at 42 C.F.R. Sec. 433.68(e)(2).

24 (2) "Continuing care retirement community" means a facility that  
25 provides a continuum of services by one operational entity or related  
26 organization providing independent living services, or boarding home or  
27 assisted living services under chapter 18.20 RCW, and skilled nursing  
28 services under chapter 18.51 RCW in a single contiguous campus. The  
29 number of licensed nursing home beds must be sixty percent or less of  
30 the total number of beds available in the entire continuing care  
31 retirement community. For purposes of this subsection "contiguous"  
32 means land adjoining or touching other property held by the same or  
33 related organization including land divided by a public road.

34 (3) "Deductions from revenue" means reductions from gross revenue  
35 resulting from an inability to collect payment of charges. Such  
36 reductions include bad debt, contractual adjustments, policy discounts  
37 and adjustments, and other such revenue deductions.

- 1 (4) "Department" means the department of social and health  
2 services.
- 3 (5) "Fund" means the skilled nursing facility safety net trust  
4 fund.
- 5 (6) "Hospital based" means a nursing facility that is physically  
6 part of, or contiguous to, a hospital. For purposes of this subsection  
7 "contiguous" has the same meaning as in subsection (2) of this section.
- 8 (7) "Medicare patient day" means a patient day for medicare  
9 beneficiaries on a medicare part A stay, medicare hospice stay, and a  
10 patient day for persons who have opted for managed care coverage using  
11 their medicare benefit.
- 12 (8) "Medicare upper payment limit" means the limitation established  
13 by federal regulations, 42 C.F.R. Sec. 447.272, that disallows federal  
14 matching funds when state medicaid agencies pay certain classes of  
15 nursing facilities an aggregate amount for services that would exceed  
16 the amount that would be paid for the same services furnished by that  
17 class of nursing facilities under medicare payment principles.
- 18 (9) "Net resident service revenue" means gross revenue from  
19 services to nursing facility residents less deductions from revenue.  
20 Net resident service revenue does not include other operating revenue  
21 or nonoperating revenue.
- 22 (10) "Nonexempt nursing facility" means a nursing facility that is  
23 not exempt from the skilled nursing facility safety net assessment.
- 24 (11) "Nonoperating revenue" means income from activities not  
25 relating directly to the day-to-day operations of an organization.  
26 Nonoperating revenue includes such items as gains on disposal of a  
27 facility's assets, dividends, and interest from security investments,  
28 gifts, grants, and endowments.
- 29 (12) "Nursing facility," "facility," or "skilled nursing facility"  
30 has the same meaning as "nursing home" as defined in RCW 18.51.010.
- 31 (13) "Other operating revenue" means income from nonresident care  
32 services to residents, as well as sales and activities to persons other  
33 than residents. It is derived in the course of operating the facility  
34 such as providing personal laundry service for residents or from other  
35 sources such as meals provided to persons other than residents,  
36 personal telephones, gift shops, and vending machines.
- 37 (14) "Related organization" means an entity which is under common

1 ownership and/or control with, or has control of, or is controlled by,  
2 the contractor, as defined under chapter 74.46 RCW.

3 (a) "Common ownership" exists when an entity is the beneficial  
4 owner of five percent or more ownership interest in the contractor, as  
5 defined under chapter 74.46 RCW and any other entity.

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

10 (15) "Resident day" means a calendar day of care provided to a  
11 nursing facility resident, excluding medicare patient days. Resident  
12 days include the day of admission and exclude the day of discharge. An  
13 admission and discharge on the same day count as one day of care.  
14 Resident days include nursing facility hospice days and exclude bedhold  
15 days for all residents.

16 NEW SECTION. **Sec. 14.** SKILLED NURSING FACILITY SAFETY NET  
17 ASSESSMENT FUND. (1) There is established in the state treasury the  
18 skilled nursing facility safety net trust fund. The purpose and use of  
19 the fund shall be to receive and disburse funds, together with accrued  
20 interest, in accordance with this chapter. Moneys in the fund,  
21 including interest earned, shall not be used or disbursed for any  
22 purposes other than those specified in this chapter. Any amounts  
23 expended from the fund that are later recouped by the department on  
24 audit or otherwise shall be returned to the fund.

25 (2) The skilled nursing facility safety net trust fund must be a  
26 separate and continuing fund, and no money in the fund reverts to the  
27 state general fund at any time. All assessments, interest, and  
28 penalties collected by the department under sections 15, 16, and 20 of  
29 this act shall be deposited into the fund.

30 (3) Any money received under sections 15, 16, and 20 of this act  
31 must be deposited in the state treasury for credit to the skilled  
32 nursing facility safety net trust fund, and must be expended, to the  
33 extent authorized by federal law, to obtain federal financial  
34 participation in the medicaid program and to maintain and enhance  
35 nursing facility rates in a manner set forth in subsection (4) of this  
36 section.

37 (4) Disbursements from the fund may be made only as follows:

1 (a) As an immediate pass-through or rate add-on to reimburse the  
2 medicaid share of the skilled nursing facility safety net assessment as  
3 a medicaid allowable cost;

4 (b) To make medicaid payments for nursing facility services in  
5 accordance with chapter 74.46 RCW and pursuant to this chapter;

6 (c) To refund erroneous or excessive payments made by skilled  
7 nursing facilities pursuant to this chapter;

8 (d) To administer the provisions of this chapter the department may  
9 expend an amount not to exceed one-half of one percent of the money  
10 received from the assessment, and must not exceed the amount authorized  
11 for expenditure by the legislature for administrative expenses in a  
12 fiscal year;

13 (e) To repay the federal government for any excess payments made to  
14 skilled nursing facilities from the fund if the assessments or payment  
15 increases set forth in this chapter are deemed out of compliance with  
16 federal statutes and regulations and all appeals have been exhausted.  
17 In such a case, the department may require skilled nursing facilities  
18 receiving excess payments to refund the payments in question to the  
19 fund. The state in turn shall return funds to the federal government  
20 in the same proportion as the original financing. If a skilled nursing  
21 facility is unable to refund payments, the state shall either develop  
22 a payment plan or deduct moneys from future medicaid payments, or both;  
23 and

24 (f) To increase nursing facility payments to fund covered services  
25 to medicaid beneficiaries within medicare upper limits.

26 (5) Any positive balance in the fund at the end of a fiscal year  
27 shall be applied to reduce the assessment amount for the subsequent  
28 fiscal year in accordance with section 16(1)(c)(i) of this act.

29 (6) Upon termination of the assessment, any amounts remaining in  
30 the fund shall be refunded to skilled nursing facilities, pro rata  
31 according to the amount paid by the facility, subject to limitations of  
32 federal law.

33 NEW SECTION. **Sec. 15.** ASSESSMENTS. (1) In accordance with the  
34 redistribution method set forth in 42 C.F.R. Sec. 433.68(e)(1) and (2),  
35 the department shall seek a waiver of the broad-based and uniform  
36 provider assessment requirements of federal law to exclude certain  
37 nursing facilities from the skilled nursing facility safety net

1 assessment and to permit certain high volume medicaid nursing  
2 facilities or facilities with a high number of total annual resident  
3 days to pay the skilled nursing facility safety net assessment at a  
4 lesser amount per nonmedicare patient day.

5 (2) The skilled nursing facility safety net assessment shall, at no  
6 time, be greater than the maximum percentage of the nursing facility  
7 industry reported net patient service revenues allowed under federal  
8 law or regulation.

9 (3) All skilled nursing facility safety net assessments collected  
10 pursuant to this section by the department shall be transmitted to the  
11 state treasurer who shall credit all such amounts to the skilled  
12 nursing facility safety net trust fund.

13 NEW SECTION. **Sec. 16.** ADMINISTRATION AND COLLECTION. (1) The

14 department, in cooperation with the office of financial management,  
15 shall develop rules for determining the amount to be assessed to  
16 individual skilled nursing facilities, notifying individual skilled  
17 nursing facilities of the assessed amount, and collecting the amounts  
18 due. Such rule making shall specifically include provision for:

- 19 (a) Payment of the skilled nursing facility safety net assessment;
- 20 (b) Interest on delinquent assessments;
- 21 (c) Adjustment of the assessment amounts as follows:

22 (i) The assessment amounts under section 15 of this act may be  
23 adjusted as follows:

24 (A) If sufficient other appropriated funds for skilled nursing  
25 facilities, are available to support the nursing facility reimbursement  
26 rates as authorized in the biennial appropriations act and other uses  
27 and payments permitted by sections 14 and 15 of this act without  
28 utilizing the full assessment authorized under section 15 of this act,  
29 the department shall reduce the amount of the assessment to the minimum  
30 level necessary to support those reimbursement rates and other uses and  
31 payments.

32 (B) So long as none of the conditions set forth in section 18(2) of  
33 this act have occurred, if the department's forecasts indicate that the  
34 assessment amounts under section 15 of this act, together with all  
35 other appropriated funds, are not sufficient to support the skilled  
36 nursing facility reimbursement rates authorized in the biennial  
37 appropriations act and other uses and payments authorized under



1 sections 14 and 15 of this act, the department shall increase the  
2 assessment rates to the amount necessary to support those reimbursement  
3 rates and other payments to the maximum amount allowable under federal  
4 law.

5 (C) Any positive balance remaining in the fund at the end of the  
6 fiscal year shall be applied to reduce the assessment amount for the  
7 subsequent fiscal year.

8 (ii) Beginning July 1, 2012, any adjustment to the assessment  
9 amounts pursuant to this subsection, and the data supporting such  
10 adjustment, including but not limited to relevant data listed in  
11 subsection (2) of this section, must be submitted to the Washington  
12 health care association, and aging services of Washington, for review  
13 and comment at least sixty calendar days prior to implementation of  
14 such adjusted assessment amounts. Any review and comment provided by  
15 the Washington health care association, and aging services of  
16 Washington, shall not limit the ability of either association or its  
17 members to challenge an adjustment or other action by the department  
18 that is not made in accordance with this chapter.

19 (2) By November 30th of each year, the department shall provide the  
20 following data to the office of financial management, the chair of the  
21 fiscal committee of the senate and the house of representatives, the  
22 Washington health care association, and aging services of Washington:

- 23 (a) The fund balance; and
- 24 (b) The amount of assessment paid by each skilled nursing facility.
- 25 (3) Assessments shall be assessed from the effective date of this  
26 section.

27 NEW SECTION. **Sec. 17.** EXCEPTIONS. (1) Subject to subsection (4)  
28 of this section the department shall exempt the following nursing  
29 facility providers from the skilled nursing facility safety net  
30 assessment subject to federal approval under 42 C.F.R. Sec.  
31 433.68(e)(2):

- 32 (a) Continuing care retirement communities;
- 33 (b) Nursing facilities with thirty-five or fewer licensed beds;
- 34 (c) State, tribal, and county operated nursing facilities; and
- 35 (d) Any nursing facility operated by a public hospital district and  
36 nursing facilities that are hospital-based.

1 (2) The department shall lower the skilled nursing facility safety  
2 net assessment for either certain high volume medicaid nursing  
3 facilities or certain facilities with high resident volumes to meet the  
4 redistributive tests of 42 C.F.R. Sec. 433.68(e)(2).

5 (3) The department shall lower the skilled nursing facility safety  
6 net assessment for any skilled nursing facility with a licensed bed  
7 capacity in excess of two hundred three beds to the same level  
8 described in subsection (2) of this section.

9 (4) To the extent necessary to obtain federal approval under 42  
10 C.F.R. Sec. 433.68(e)(2), the exemptions prescribed in subsections (1),  
11 (2), and (3) of this section may be amended by the department.

12 (5) The per resident day assessment rate shall be the same amount  
13 for each affected facility except as prescribed in subsections (1),  
14 (2), and (3) of this section.

15 (6) The department shall notify the nursing facility operators of  
16 any skilled nursing facilities that would be exempted from the skilled  
17 nursing facility safety net assessment pursuant to the waiver request  
18 submitted to the United States department of health and human services  
19 under this section.

20 NEW SECTION. **Sec. 18.** CONDITIONS. (1) If the centers for  
21 medicare and medicaid services fail to approve any state plan  
22 amendments or waiver requests that are necessary in order to implement  
23 the applicable sections of this chapter then the assessment authorized  
24 in section 16 of this act shall cease to be imposed.

25 (2) Nothing in subsection (1) of this section prohibits the  
26 department from working cooperatively with the centers for medicare and  
27 medicaid services to secure approval of any needed state plan  
28 amendments or waiver requests. As provided in sections 15 and 17 of  
29 this act, the department shall adjust any submitted state plan  
30 amendments or waiver requests as necessary to achieve approval.

31 (3) If this chapter does not take effect or ceases to be imposed,  
32 any moneys remaining in the fund shall be refunded to skilled nursing  
33 facilities in proportion to the amounts paid by such facilities.

34 NEW SECTION. **Sec. 19.** ASSESSMENT PART OF OPERATING OVERHEAD. The  
35 incidence and burden of assessments imposed under this chapter shall be  
36 on skilled nursing facilities and the expense associated with the

1 assessments shall constitute a part of the operating overhead of the  
2 facilities. Skilled nursing facilities shall not itemize the safety  
3 net assessment on billings to residents or third-party payers.

4 NEW SECTION. **Sec. 20.** ENFORCEMENT. If a nursing facility fails  
5 to make timely payment of the safety net assessment, the department may  
6 seek a remedy provided by law, including, but not limited to:

- 7 (1) Withholding any medical assistance reimbursement payments until  
8 such time as the assessment amount is recovered;
- 9 (2) Suspension or revocation of the nursing facility license; or
- 10 (3) Imposition of a civil fine up to one thousand dollars per day  
11 for each delinquent payment, not to exceed the amount of the  
12 assessment.

13 NEW SECTION. **Sec. 21.** QUALITY INCENTIVE PAYMENTS. (1) The  
14 department and the department of health, in consultation with the  
15 Washington state health care association, and aging services of  
16 Washington, shall design a system of skilled nursing facility quality  
17 incentive payments. The design of the system shall be submitted to the  
18 relevant policy and fiscal committees of the legislature by December  
19 15, 2011. The system shall be based upon the following principles:

- 20 (a) Evidence-based treatment and processes shall be used to improve  
21 health care outcomes for skilled nursing facility residents;
- 22 (b) Effective purchasing strategies to improve the quality of  
23 health care services should involve the use of common quality  
24 improvement measures, while recognizing that some measures may not be  
25 appropriate for application to facilities with high bariatric,  
26 behaviorally challenged, or rehabilitation populations;
- 27 (c) Quality measures chosen for the system should be consistent  
28 with the standards that have been developed by national quality  
29 improvement organizations, such as the national quality forum, the  
30 federal centers for medicare and medicaid services, or the federal  
31 agency for healthcare research and quality. New reporting burdens to  
32 skilled nursing facilities should be minimized by giving priority to  
33 measures skilled nursing facilities that are currently required to  
34 report to governmental agencies, such as the nursing home compare  
35 measures collected by the federal centers for medicare and medicaid  
36 services;

1 (d) Benchmarks for each quality improvement measure should be set  
2 at levels that are feasible for skilled nursing facilities to achieve,  
3 yet represent real improvements in quality and performance for a  
4 majority of skilled nursing facilities in Washington state; and

5 (e) Skilled nursing facilities performance and incentive payments  
6 should be designed in a manner such that all facilities in Washington  
7 are able to receive the incentive payments if performance is at or  
8 above the benchmark score set in the system established under this  
9 section.

10 (2) Pursuant to an appropriation by the legislature, for state  
11 fiscal year 2013 and each fiscal year thereafter, assessments may be  
12 increased to support an additional one percent increase in skilled  
13 nursing facility reimbursement rates for facilities that meet the  
14 quality incentive benchmarks established under this section.

15 **Sec. 22.** RCW 43.84.092 and 2010 1st sp.s. c 30 s 20, 2010 1st  
16 sp.s. c 9 s 7, 2010 c 248 s 6, 2010 c 222 s 5, 2010 c 162 s 6, and 2010  
17 c 145 s 11 are each reenacted and amended to read as follows:

18 (1) All earnings of investments of surplus balances in the state  
19 treasury shall be deposited to the treasury income account, which  
20 account is hereby established in the state treasury.

21 (2) The treasury income account shall be utilized to pay or receive  
22 funds associated with federal programs as required by the federal cash  
23 management improvement act of 1990. The treasury income account is  
24 subject in all respects to chapter 43.88 RCW, but no appropriation is  
25 required for refunds or allocations of interest earnings required by  
26 the cash management improvement act. Refunds of interest to the  
27 federal treasury required under the cash management improvement act  
28 fall under RCW 43.88.180 and shall not require appropriation. The  
29 office of financial management shall determine the amounts due to or  
30 from the federal government pursuant to the cash management improvement  
31 act. The office of financial management may direct transfers of funds  
32 between accounts as deemed necessary to implement the provisions of the  
33 cash management improvement act, and this subsection. Refunds or  
34 allocations shall occur prior to the distributions of earnings set  
35 forth in subsection (4) of this section.

36 (3) Except for the provisions of RCW 43.84.160, the treasury income  
37 account may be utilized for the payment of purchased banking services

1 on behalf of treasury funds including, but not limited to, depository,  
2 safekeeping, and disbursement functions for the state treasury and  
3 affected state agencies. The treasury income account is subject in all  
4 respects to chapter 43.88 RCW, but no appropriation is required for  
5 payments to financial institutions. Payments shall occur prior to  
6 distribution of earnings set forth in subsection (4) of this section.

7 (4) Monthly, the state treasurer shall distribute the earnings  
8 credited to the treasury income account. The state treasurer shall  
9 credit the general fund with all the earnings credited to the treasury  
10 income account except:

11 (a) The following accounts and funds shall receive their  
12 proportionate share of earnings based upon each account's and fund's  
13 average daily balance for the period: The aeronautics account, the  
14 aircraft search and rescue account, the budget stabilization account,  
15 the capitol building construction account, the Cedar River channel  
16 construction and operation account, the Central Washington University  
17 capital projects account, the charitable, educational, penal and  
18 reformatory institutions account, the cleanup settlement account, the  
19 Columbia river basin water supply development account, the common  
20 school construction fund, the county arterial preservation account, the  
21 county criminal justice assistance account, the county sales and use  
22 tax equalization account, the deferred compensation administrative  
23 account, the deferred compensation principal account, the department of  
24 licensing services account, the department of retirement systems  
25 expense account, the developmental disabilities community trust  
26 account, the drinking water assistance account, the drinking water  
27 assistance administrative account, the drinking water assistance  
28 repayment account, the Eastern Washington University capital projects  
29 account, the education construction fund, the education legacy trust  
30 account, the election account, the energy freedom account, the energy  
31 recovery act account, the essential rail assistance account, The  
32 Evergreen State College capital projects account, the federal forest  
33 revolving account, the ferry bond retirement fund, the freight  
34 congestion relief account, the freight mobility investment account, the  
35 freight mobility multimodal account, the grade crossing protective  
36 fund, the public health services account, the health system capacity  
37 account, the high capacity transportation account, the state higher  
38 education construction account, the higher education construction

1 account, the highway bond retirement fund, the highway infrastructure  
2 account, the highway safety account, the high occupancy toll lanes  
3 operations account, the hospital safety net assessment fund, the  
4 industrial insurance premium refund account, the judges' retirement  
5 account, the judicial retirement administrative account, the judicial  
6 retirement principal account, the local leasehold excise tax account,  
7 the local real estate excise tax account, the local sales and use tax  
8 account, the marine resources stewardship trust account, the medical  
9 aid account, the mobile home park relocation fund, the motor vehicle  
10 fund, the motorcycle safety education account, the multiagency  
11 permitting team account, the multimodal transportation account, the  
12 municipal criminal justice assistance account, the municipal sales and  
13 use tax equalization account, the natural resources deposit account,  
14 the oyster reserve land account, the pension funding stabilization  
15 account, the perpetual surveillance and maintenance account, the public  
16 employees' retirement system plan 1 account, the public employees'  
17 retirement system combined plan 2 and plan 3 account, the public  
18 facilities construction loan revolving account beginning July 1, 2004,  
19 the public health supplemental account, the public transportation  
20 systems account, the public works assistance account, the Puget Sound  
21 capital construction account, the Puget Sound ferry operations account,  
22 the Puyallup tribal settlement account, the real estate appraiser  
23 commission account, the recreational vehicle account, the regional  
24 mobility grant program account, the resource management cost account,  
25 the rural arterial trust account, the rural Washington loan fund, the  
26 site closure account, the skilled nursing facility safety net trust  
27 fund, the small city pavement and sidewalk account, the special  
28 category C account, the special wildlife account, the state employees'  
29 insurance account, the state employees' insurance reserve account, the  
30 state investment board expense account, the state investment board  
31 commingled trust fund accounts, the state patrol highway account, the  
32 state route number 520 civil penalties account, the state route number  
33 520 corridor account, the supplemental pension account, the Tacoma  
34 Narrows toll bridge account, the teachers' retirement system plan 1  
35 account, the teachers' retirement system combined plan 2 and plan 3  
36 account, the tobacco prevention and control account, the tobacco  
37 settlement account, the transportation 2003 account (nickel account),  
38 the transportation equipment fund, the transportation fund, the

1 transportation improvement account, the transportation improvement  
2 board bond retirement account, the transportation infrastructure  
3 account, the transportation partnership account, the traumatic brain  
4 injury account, the tuition recovery trust fund, the University of  
5 Washington bond retirement fund, the University of Washington building  
6 account, the urban arterial trust account, the volunteer firefighters'  
7 and reserve officers' relief and pension principal fund, the volunteer  
8 firefighters' and reserve officers' administrative fund, the Washington  
9 judicial retirement system account, the Washington law enforcement  
10 officers' and firefighters' system plan 1 retirement account, the  
11 Washington law enforcement officers' and firefighters' system plan 2  
12 retirement account, the Washington public safety employees' plan 2  
13 retirement account, the Washington school employees' retirement system  
14 combined plan 2 and 3 account, the Washington state health insurance  
15 pool account, the Washington state patrol retirement account, the  
16 Washington State University building account, the Washington State  
17 University bond retirement fund, the water pollution control revolving  
18 fund, and the Western Washington University capital projects account.  
19 Earnings derived from investing balances of the agricultural permanent  
20 fund, the normal school permanent fund, the permanent common school  
21 fund, the scientific permanent fund, and the state university permanent  
22 fund shall be allocated to their respective beneficiary accounts.

23 (b) Any state agency that has independent authority over accounts  
24 or funds not statutorily required to be held in the state treasury that  
25 deposits funds into a fund or account in the state treasury pursuant to  
26 an agreement with the office of the state treasurer shall receive its  
27 proportionate share of earnings based upon each account's or fund's  
28 average daily balance for the period.

29 (5) In conformance with Article II, section 37 of the state  
30 Constitution, no treasury accounts or funds shall be allocated earnings  
31 without the specific affirmative directive of this section.

32 NEW SECTION. **Sec. 23.** RCW 74.46.433 (Variable return component  
33 rate allocation) and 2010 1st sp.s. c 34 s 4, 2006 c 258 s 3, 2001 1st  
34 sp.s. c 8 s 6, & 1999 c 353 s 9 are each repealed.

35 NEW SECTION. **Sec. 24.** Except as provided in section 18 of this  
36 act, if any provision of this act or its application to any person or

1 circumstance is held invalid, the remainder of the act or the  
2 application of the provision to other persons or circumstances is not  
3 affected.

4 NEW SECTION. **Sec. 25.** Sections 12 through 21 and 24 of this act  
5 constitute a new chapter in Title 74 RCW.

6 NEW SECTION. **Sec. 26.** This act is necessary for the immediate  
7 preservation of the public peace, health, or safety, or support of the  
8 state government and its existing public institutions, and takes effect  
9 July 1, 2011.

Passed by the Senate May 11, 2011.

Passed by the House May 17, 2011.

Approved by the Governor May 31, 2011.

Filed in Office of Secretary of State June 1, 2011.