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**SUBSTITUTE SENATE BILL 6240**

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**State of Washington**

**64th Legislature**

**2016 Regular Session**

**By** Senate Health Care (originally sponsored by Senators Parlette, Keiser, Becker, Cleveland, Bailey, McAuliffe, and Hobbs)

READ FIRST TIME 02/05/16.

1 AN ACT Relating to nursing home facilities; amending RCW  
2 74.46.561, 74.42.360, 74.46.020, 74.46.501, 74.46.835, and 74.46.581;  
3 reenacting and amending RCW 74.42.010; repealing RCW 74.46.803,  
4 74.46.807, 74.46.437, and 74.46.439; and prescribing penalties.

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

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

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

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

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

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

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

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

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

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

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

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

10 (d) Each facility must be paid at eighty-three percent or greater  
11 of the median nursing facility RS means construction index value per  
12 square foot for Washington state. The department may use updated RS  
13 means construction index information when more recent square footage  
14 data becomes available. The statewide value per square foot must be  
15 indexed based on facility zip code by multiplying the statewide value  
16 per square foot times the appropriate zip code based index. For the  
17 purpose of implementing this section, the value per square foot  
18 effective July 1, 2016, must be set so that the weighted average FRV  
19 rate is not less than ten dollars and eighty cents ppd. The capital  
20 component rate allocations calculated in accordance with this section  
21 must be adjusted to the extent necessary to comply with RCW  
22 74.46.421.

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

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

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

6 (a) An enhancement no larger than five percent and no less than  
7 one percent of the statewide average daily rate must be paid to  
8 facilities that meet or exceed the standard established for the  
9 quality incentive. All providers must have the opportunity to earn  
10 the full quality incentive payment. ((The department must recommend  
11 four to six measures to become the standard for the quality  
12 incentive, and must describe a system for rewarding incremental  
13 improvement related to these four to six measures, within the report  
14 to the legislature described in section 6, chapter 2, Laws of 2015  
15 2nd sp. sess. Infection rates, pressure ulcers, staffing turnover,  
16 fall prevention, utilization of antipsychotic medication, and  
17 hospital readmission rates are examples of measures that may be  
18 established for the quality incentive.))

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

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

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

9 (e) Facilities receiving an aggregate quality score of eighty  
10 percent of the overall available total score or higher must be placed  
11 in the highest tier (Tier V), facilities receiving an aggregate score  
12 of between seventy and seventy-nine percent of the overall available  
13 total score must be placed in the second highest tier (Tier IV),  
14 facilities receiving an aggregate score of between sixty and sixty-  
15 nine percent of the overall available total score must be placed in  
16 the third highest tier (Tier III), facilities receiving an aggregate  
17 score of between fifty and fifty-nine percent of the overall  
18 available total score must be placed in the fourth highest tier (Tier  
19 II), and facilities receiving less than fifty percent of the overall  
20 available total score must be placed in the lowest tier (Tier I).

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

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

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

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

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

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

20       (7) Reimbursement of the safety net assessment imposed by chapter  
21 74.48 RCW and paid in relation to medicaid residents must be  
22 continued.

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

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

1 74.46.022(6) must be used for technical assistance, specialized  
2 training, or an increase to the quality enhancement established in  
3 subsection (6) of this section. The legislature intends to review the  
4 utility of maintaining the reconciliation and settlement process  
5 under a price-based payment methodology, and may discontinue the  
6 reconciliation and settlement process after the 2017-2019 fiscal  
7 biennium.

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

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

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

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

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

1 (b) The department shall establish in rule by January 1, 2016, a  
2 system of financial penalties for facilities out of compliance with  
3 minimum staffing standards. No monetary penalty may be issued during  
4 the implementation period of July 1, 2016, through September 30,  
5 2016. If a facility is found noncompliant during the implementation  
6 period, the department shall provide a written notice identifying the  
7 staffing deficiency and require the facility to provide a  
8 sufficiently detailed correction plan to meet the statutory minimum  
9 staffing levels. Monetary penalties begin October 1, 2016. Monetary  
10 penalties must be established based on a formula that calculates the  
11 cost of wages and benefits for the missing staff hours. If a facility  
12 meets the requirements in subsection (3) or (4) of this section, the  
13 penalty amount must be based solely on the wages and benefits of  
14 certified nurse aides. The first monetary penalty for noncompliance  
15 must be at a lower amount than subsequent findings of noncompliance.  
16 Monetary penalties established by the department may not exceed two  
17 hundred percent of the wage and benefit costs that would have  
18 otherwise been expended to achieve the required staffing minimum HPRD  
19 for the quarter. A facility found out of compliance must be assessed  
20 a monetary penalty at the lowest penalty level if the facility has  
21 met or exceeded the requirements in subsection (2) of this section  
22 for three or more consecutive years. Beginning July 1, 2016, pursuant  
23 to rules established by the department, funds that are received from  
24 financial penalties must be used for technical assistance,  
25 specialized training, or an increase to the quality enhancement  
26 established in RCW 74.46.561.

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

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

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

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



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

3 (d)(i) The department shall establish a limited exception to the  
4 3.4 HPRD staffing requirement for facilities demonstrating a good  
5 faith effort to hire and retain staff.

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

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

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

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

11 (vi) The department may grant exceptions for a six-month period  
12 per exception. The department's authority to grant exceptions to the  
13 3.4 HPRD staffing requirement expires June 30, 2018.

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

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

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

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

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

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

5 (2) "Facility" refers to a nursing home as defined in RCW  
6 18.51.010.

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

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

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

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

18 (7) "Physician" means a person practicing pursuant to chapter  
19 18.57 or 18.71 RCW, including, but not limited to, a physician  
20 employed by the facility as provided in chapter 18.51 RCW.

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

23 (9) "Qualified therapist" means:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 (9) (~~("Certificate of capital authorization" means a~~  
19 ~~certification from the department for an allocation from the biennial~~  
20 ~~capital financing authorization for all new or replacement building~~  
21 ~~construction, or for major renovation projects, receiving a~~  
22 ~~certificate of need or a certificate of need exemption under chapter~~  
23 ~~70.38 RCW after July 1, 2001.~~

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

29 ((+11)) (10) "Default case" means no initial assessment has been  
30 completed for a resident and transmitted to the department by the  
31 cut-off date, or an assessment is otherwise past due for the  
32 resident, under state and federal requirements.

33 ((+12)) (11) "Department" means the department of social and  
34 health services (DSHS) and its employees.

35 ((+13)) (12) "Depreciation" means the systematic distribution of  
36 the cost or other basis of tangible assets, less salvage, over the  
37 estimated useful life of the assets.

38 ((+14)) (13) "Direct care component" means nursing care and  
39 related care provided to nursing facility residents and includes the  
40 therapy care component, along with food, laundry, and dietary

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

3 ~~(15))~~ (14) "Direct care supplies" means medical, pharmaceutical,  
4 and other supplies required for the direct care of a nursing  
5 facility's residents.

6 ~~((16))~~ (15) "Entity" means an individual, partnership,  
7 corporation, limited liability company, or any other association of  
8 individuals capable of entering enforceable contracts.

9 ~~((17))~~ (16) "Equity" means the net book value of all tangible  
10 and intangible assets less the recorded value of all liabilities, as  
11 recognized and measured in conformity with generally accepted  
12 accounting principles.

13 ~~((18))~~ (17) "Essential community provider" means a facility  
14 which is the only nursing facility within a commuting distance radius  
15 of at least forty minutes duration, traveling by automobile.

16 ~~((19))~~ (18) "Facility" or "nursing facility" means a nursing  
17 home licensed in accordance with chapter 18.51 RCW, excepting nursing  
18 homes certified as institutions for mental diseases, or that portion  
19 of a multiservice facility licensed as a nursing home, or that  
20 portion of a hospital licensed in accordance with chapter 70.41 RCW  
21 which operates as a nursing home.

22 ~~((20))~~ (19) "Fair market value" means the replacement cost of  
23 an asset less observed physical depreciation on the date for which  
24 the market value is being determined.

25 ~~((21))~~ (20) "Financial statements" means statements prepared  
26 and presented in conformity with generally accepted accounting  
27 principles including, but not limited to, balance sheet, statement of  
28 operations, statement of changes in financial position, and related  
29 notes.

30 ~~((22))~~ (21) "Generally accepted accounting principles" means  
31 accounting principles approved by the financial accounting standards  
32 board (FASB) or its successor.

33 ~~((23))~~ (22) "Grouper" means a computer software product that  
34 groups individual nursing facility residents into case mix  
35 classification groups based on specific resident assessment data and  
36 computer logic.

37 ~~((24))~~ (23) "High labor-cost county" means an urban county in  
38 which the median allowable facility cost per case mix unit is more  
39 than ten percent higher than the median allowable facility cost per  
40 case mix unit among all other urban counties, excluding that county.

1        ~~((25))~~ (24) "Historical cost" means the actual cost incurred in  
2 acquiring and preparing an asset for use, including feasibility  
3 studies, architect's fees, and engineering studies.

4        ~~((26))~~ (25) "Home and central office costs" means costs that  
5 are incurred in the support and operation of a home and central  
6 office. Home and central office costs include centralized services  
7 that are performed in support of a nursing facility. The department  
8 may exclude from this definition costs that are nonduplicative,  
9 documented, ordinary, necessary, and related to the provision of care  
10 services to authorized patients.

11        ~~((27))~~ (26) "Large nonessential community providers" means  
12 nonessential community providers with more than sixty licensed beds,  
13 regardless of how many beds are set up or in use.

14        ~~((28))~~ (27) "Lease agreement" means a contract between two  
15 parties for the possession and use of real or personal property or  
16 assets for a specified period of time in exchange for specified  
17 periodic payments. Elimination (due to any cause other than death or  
18 divorce) or addition of any party to the contract, expiration, or  
19 modification of any lease term in effect on January 1, 1980, or  
20 termination of the lease by either party by any means shall  
21 constitute a termination of the lease agreement. An extension or  
22 renewal of a lease agreement, whether or not pursuant to a renewal  
23 provision in the lease agreement, shall be considered a new lease  
24 agreement. A strictly formal change in the lease agreement which  
25 modifies the method, frequency, or manner in which the lease payments  
26 are made, but does not increase the total lease payment obligation of  
27 the lessee, shall not be considered modification of a lease term.

28        ~~((29))~~ (28) "Medical care program" or "medicaid program" means  
29 medical assistance, including nursing care, provided under RCW  
30 74.09.500 or authorized state medical care services.

31        ~~((30))~~ (29) "Medical care recipient," "medicaid recipient," or  
32 "recipient" means an individual determined eligible by the department  
33 for the services provided under chapter 74.09 RCW.

34        ~~((31))~~ (30) "Minimum data set" means the overall data component  
35 of the resident assessment instrument, indicating the strengths,  
36 needs, and preferences of an individual nursing facility resident.

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

39        ~~((33))~~ (32) "Net invested funds" means the net book value of  
40 tangible fixed assets employed by a contractor to provide services

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

4 ~~((+34))~~ (33) "Nonurban county" means a county which is not  
5 located in a metropolitan statistical area as determined and defined  
6 by the United States office of management and budget or other  
7 appropriate agency or office of the federal government.

8 ~~((+35))~~ (34) "Owner" means a sole proprietor, general or limited  
9 partners, members of a limited liability company, and beneficial  
10 interest holders of five percent or more of a corporation's  
11 outstanding stock.

12 ~~((+36))~~ (35) "Patient day" or "resident day" means a calendar  
13 day of care provided to a nursing facility resident, regardless of  
14 payment source, which will include the day of admission and exclude  
15 the day of discharge; except that, when admission and discharge occur  
16 on the same day, one day of care shall be deemed to exist. A  
17 "medicaid day" or "recipient day" means a calendar day of care  
18 provided to a medicaid recipient determined eligible by the  
19 department for services provided under chapter 74.09 RCW, subject to  
20 the same conditions regarding admission and discharge applicable to a  
21 patient day or resident day of care.

22 ~~((+37))~~ (36) "Qualified therapist" means:

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

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

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

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

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

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

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



1 ((+39+)) (38) "Rebased rate" or "cost-rebased rate" means a  
2 facility-specific component rate assigned to a nursing facility for a  
3 particular rate period established on desk-reviewed, adjusted costs  
4 reported for that facility covering at least six months of a prior  
5 calendar year designated as a year to be used for cost-rebasing  
6 payment rate allocations under the provisions of this chapter.

7 ((+40+)) (39) "Records" means those data supporting all financial  
8 statements and cost reports including, but not limited to, all  
9 general and subsidiary ledgers, books of original entry, and  
10 transaction documentation, however such data are maintained.

11 ((+41+)) (40) "Resident assessment instrument," including  
12 federally approved modifications for use in this state, means a  
13 federally mandated, comprehensive nursing facility resident care  
14 planning and assessment tool, consisting of the minimum data set and  
15 resident assessment protocols.

16 ((+42+)) (41) "Resident assessment protocols" means those  
17 components of the resident assessment instrument that use the minimum  
18 data set to trigger or flag a resident's potential problems and risk  
19 areas.

20 ((+43+)) (42) "Resource utilization groups" means a case mix  
21 classification system that identifies relative resources needed to  
22 care for an individual nursing facility resident.

23 ((+44+)) (43) "Secretary" means the secretary of the department  
24 of social and health services.

25 ((+45+)) (44) "Small nonessential community providers" means  
26 nonessential community providers with sixty or fewer licensed beds,  
27 regardless of how many beds are set up or in use.

28 ~~((+46+)) "Support services" means food, food preparation, dietary,~~  
29 ~~housekeeping, and laundry services provided to nursing facility~~  
30 ~~residents.~~

31 ~~(+47+))~~ (45) "Therapy care" means those services required by a  
32 nursing facility resident's comprehensive assessment and plan of  
33 care, that are provided by qualified therapists, or support personnel  
34 under their supervision, including related costs as designated by the  
35 department.

36 ((+48+)) (46) "Title XIX" or "medicaid" means the 1965 amendments  
37 to the social security act, P.L. 89-07, as amended and the medicaid  
38 program administered by the department.

39 ((+49+)) (47) "Urban county" means a county which is located in a  
40 metropolitan statistical area as determined and defined by the United

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

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

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

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

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

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

18 (2)(a) In calculating a facility's two average case mix indexes  
19 for each quarter, the department shall include all residents or  
20 medicaid residents, as applicable, who were physically in the  
21 facility during the quarter in question based on the resident  
22 assessment instrument completed by the facility and the requirements  
23 and limitations for the instrument's completion and transmission  
24 (January 1st through March 31st, April 1st through June 30th, July  
25 1st through September 30th, or October 1st through December 31st).

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

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

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

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

7 (6)(a) Although the facility average and the medicaid average  
8 case mix indexes shall both be calculated quarterly, the cost-  
9 rebasing period facility average case mix index will be used  
10 throughout the applicable cost-rebasing period in combination with  
11 cost report data as specified by RCW (~~74.46.431 and 74.46.506~~)  
12 74.46.561, to establish a facility's allowable cost per case mix  
13 unit. To allow for the transition to minimum data set 3.0 and  
14 implementation of resource utilization group IV for July 1, 2015,  
15 through June 30, (~~2017~~) 2016, the department shall calculate rates  
16 using the medicaid average case mix scores effective for January 1,  
17 2015, rates adjusted under RCW 74.46.485(1)(a), and the scores shall  
18 be increased each six months during the transition period by one-half  
19 of one percent. The July 1, (~~2017~~) 2016, direct care cost per case  
20 mix unit shall be calculated by utilizing (~~2015~~) 2014 direct care  
21 costs, patient days, and (~~2015~~) 2014 facility average case mix  
22 indexes based on the minimum data set 3.0 resource utilization group  
23 IV grouper 57. Otherwise, a facility's medicaid average case mix  
24 index shall be used to update a nursing facility's direct care  
25 component rate semiannually.

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

32 (c) The medicaid average case mix index used to update or  
33 recalibrate a nursing facility's direct care component rate  
34 semiannually shall be from the calendar six-month period commencing  
35 nine months prior to the effective date of the semiannual rate. For  
36 example, July 1, 2010, through December 31, 2010, direct care  
37 component rates shall utilize case mix averages from the October 1,  
38 2009, through March 31, 2010, calendar quarters, and so forth.

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

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

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

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

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

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

22       A separate nursing facility quality enhancement account is  
23 created in the custody of the state treasurer. Beginning July 1,  
24 2015, all net receipts from the reconciliation and settlement process  
25 provided in RCW 74.46.022(6), as described within RCW 74.46.561, must  
26 be deposited into the account. Beginning July 1, 2016, all receipts  
27 from the system of financial penalties for facilities out of  
28 compliance with minimum staffing standards, as described within RCW  
29 74.42.360, must be deposited into the account. Only the secretary, or  
30 the secretary's designee, may authorize expenditures from the  
31 account. The account is subject to allotment procedures under chapter  
32 43.88 RCW, but an appropriation is not required for expenditures. The  
33 department shall use the special account only for technical  
34 assistance for nursing facilities, specialized training for nursing  
35 facilities, or an increase to the quality enhancement established in  
36 RCW 74.46.561, or as necessary for the reconciliation and settlement  
37 process, which requires deposits and withdrawals to complete both the  
38 preliminary and final settlement net receipt amounts for this  
39 account.

1        NEW SECTION.    **Sec. 8.**    The following acts or parts of acts are  
2 each repealed:  
3        (1) RCW 74.46.803 (Certificate of capital authorization—Rules—  
4 Emergency situations) and 2008 c 255 s 1 & 2001 1st sp.s. c 8 s 16;  
5        (2) RCW 74.46.807 (Capital authorization—Determination) and 2008  
6 c 255 s 2 & 2001 1st sp.s. c 8 s 15;  
7        (3) RCW 74.46.437 (Financing allowance component rate allocation)  
8 and 2011 1st sp.s. c 7 s 3, 2001 1st sp.s. c 8 s 8, & 1999 c 353 s  
9 11; and  
10        (4) RCW 74.46.439 (Facilities leased in arm's-length agreements—  
11 Financing allowance rate—Rate adjustment) and 2010 1st sp.s. c 34 s 7  
12 & 1999 c 353 s 12.

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