
HOUSE BILL 2466

State of Washington

64th Legislature

2016 Regular Session

By Representatives Cody, Schmick, and Van De Wege

1 AN ACT Relating to nursing home facilities; amending RCW
2 74.46.561, 74.42.360, and 74.42.010; reenacting and amending RCW
3 74.46.020; repealing RCW 74.46.803 and 74.46.807; and prescribing
4 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 case
2 mix neutral median costs. Direct care must be performance-adjusted
3 for acuity every six months, using case mix principles. Direct care
4 must be regionally adjusted (~~for nonmetropolitan and metropolitan~~
5 ~~statistical areas~~) using county wide wage index information
6 available through the United States department of labor's bureau of
7 labor statistics. There is no minimum occupancy for direct care.

8 (4) The indirect care component must include the elements of
9 administrative expenses, maintenance costs, and housekeeping services
10 from the previous system. A minimum occupancy assumption of ninety
11 percent must be applied to indirect care. Indirect care must be paid
12 at a fixed rate, based on ninety percent or greater of (~~facility-~~
13 ~~wide~~) state-wide median costs. (~~Indirect care must be regionally~~
14 ~~adjusted for nonmetropolitan and metropolitan statistical areas.~~)

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

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

33 (b) The fair rental value determined in (a) of this subsection
34 must be divided by the greater of the actual total facility census
35 from the prior full calendar year or imputed census based on the
36 number of licensed beds at ninety percent occupancy.

37 (c) For the rate year beginning July 1, 2016, all facilities must
38 be reimbursed using four hundred square feet. For the rate year
39 beginning July 1, 2017, allowable nursing facility square footage
40 must be determined using the total nursing facility square footage as

1 reported on the medicaid cost reports submitted to the department in
2 compliance with this chapter. The maximum allowable square feet per
3 bed may not exceed four hundred fifty.

4 (d) Each facility must be paid at eighty-three percent or greater
5 of the median nursing facility RS means construction index value per
6 square foot for Washington state as published in the most recent
7 addition. The statewide value per square foot must be indexed based
8 on facility zip code by multiplying the statewide value per square
9 foot times the appropriate zip code based index. For the purpose of
10 implementing this section, the value per square foot effective July
11 1, 2016, must be set so that the weighted average FRV rate is not
12 less than ten dollars and eighty cents ppd.

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

30 (f) A nursing facility's fair rental value rate allocation must
31 be rebased annually, effective July 1, 2016, in accordance with this
32 section and this chapter.

33 (g) The capital component rate allocations calculated in
34 accordance with this section must be adjusted to the extent necessary
35 to comply with RCW 74.46.421.

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

38 (a) An enhancement no larger than five percent and no less than
39 one percent of the statewide average daily rate must be paid to
40 facilities that meet or exceed the standard established for the

1 quality incentive. All providers must have the opportunity to earn
2 the full quality incentive. (~~The department must recommend four to
3 six measures to become the standard for the quality incentive, and
4 must describe a system for rewarding incremental improvement related
5 to these four to six measures, within the report to the legislature
6 described in section 6, chapter 2, Laws of 2015 2nd sp. sess.
7 Infection rates, pressure ulcers, staffing turnover, fall prevention,
8 utilization of antipsychotic medication, and hospital readmission
9 rates are examples of measures that may be established for the
10 quality incentive.~~)

11 (b) The quality incentive must be determined by calculating an
12 overall facility quality score composed of four to six quality
13 measures. Initially, the quality incentive must be based on minimum
14 data set quality measures for the percentage of long-stay residents
15 who self-report moderate to severe pain, the percentage of high-risk
16 long-stay residents with pressure ulcers, the percentage of long-stay
17 residents experiencing one or more falls with major injury, and the
18 percentage of long-stay residents with a urinary tract infection.
19 Quality measures must be reviewed on an annual basis by a quality
20 stakeholder work group established by the department. Upon review,
21 quality measures may be added or changed. The department may risk
22 adjust individual quality measures as it deems appropriate.

23 (c) The facility quality score must be point based, using at a
24 minimum the facility's most recent available three-quarter average
25 CMS quality data. Point thresholds for each quality measure must be
26 established using the corresponding statistical values for the
27 quality measure (QM) point determinants of eighty QM points, sixty QM
28 points, forty QM points, and twenty QM points, identified in the most
29 recent available five-star quality rating system technical user's
30 guide published by the center for medicare and medicaid services.

31 (d) Facilities meeting or exceeding the highest performance
32 threshold (Top level) for a quality measure receive twenty-five
33 points. Facilities meeting the second highest performance threshold
34 receive twenty points. Facilities meeting the third level of
35 performance threshold receive fifteen points. Facilities in the
36 bottom performance threshold level receive no points. Points from all
37 quality measures must then be summed into a single aggregate quality
38 score for each facility.

39 (e) Facilities receiving an aggregate quality score of eighty
40 points or higher must be placed in the highest tier (Tier V),

1 facilities receiving an aggregate score of between seventy and
2 seventy-nine points must be placed in the second highest tier (Tier
3 IV), facilities receiving an aggregate score of between sixty and
4 sixty-nine points must be placed in the third highest tier (Tier
5 III), facilities receiving an aggregate score of between fifty and
6 fifty-nine points must be placed in the fourth highest tier (Tier
7 II), and facilities receiving less than fifty points must be placed
8 in the lowest tier (Tier I).

9 (f) The tier system must be used to determine the amount of each
10 facility's per patient day quality incentive. The per patient day
11 quality incentive for Tier IV is seventy-five percent of the per
12 patient day quality incentive for Tier V, the per patient day quality
13 incentive for Tier III is fifty percent of the per patient day
14 quality incentive for Tier V, and the per patient day quality
15 incentive for Tier II is twenty-five percent of the per patient day
16 quality incentive for Tier V. Facilities in Tier I receive no quality
17 incentive.

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

21 (h) Facilities with insufficient three-quarter average CMS
22 quality data must be assigned to the tier corresponding to their
23 five-star rating. Facilities with a five-star rating must be assigned
24 to the highest tier (Tier V) and facilities with a one-star quality
25 rating must be assigned to the lowest tier (Tier I).

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

29 (7) Reimbursement of the safety net assessment imposed by chapter
30 74.48 RCW and paid in relation to medicaid residents must be
31 continued.

32 (8) The direct care and indirect care components must be rebased
33 in even-numbered years, beginning with rates paid on July 1, 2016.
34 Rates paid on July 1, 2016, must be based on the 2014 calendar year
35 cost report. On a percentage basis, after rebasing, the department
36 must confirm that the statewide average daily rate has increased at
37 least as much as the average rate of inflation, as determined by the
38 skilled nursing facility market basket index published by the centers
39 for medicare and medicaid services, or a comparable index. If after
40 rebasing, the percentage increase to the statewide average daily rate

1 is less than the average rate of inflation for the same time period,
2 the department is authorized to increase rates by the difference
3 between the percentage increase after rebasing and the average rate
4 of inflation.

5 (9) The direct care component provided in subsection (3) of this
6 section is subject to the reconciliation and settlement process
7 provided in RCW 74.46.022(6). Beginning July 1, 2016, pursuant to
8 rules established by the department, funds that are received through
9 the reconciliation and settlement process provided in RCW
10 74.46.022(6) must be used for technical assistance, specialized
11 training, or an increase to the quality enhancement established in
12 subsection (6) of this section. The legislature intends to review the
13 utility of maintaining the reconciliation and settlement process
14 under a price-based payment methodology, and may discontinue the
15 reconciliation and settlement process after the 2017-2019 fiscal
16 biennium.

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

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

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

30 (2) The department shall institute minimum staffing standards for
31 nursing homes. Beginning July 1, 2016, facilities must provide a
32 minimum of 3.4 hours per resident day of direct care. Direct care as
33 defined in RCW 74.42.010 includes registered nurses, licensed
34 practical nurses, and certified nursing assistants. The minimum
35 staffing standard includes the time when such staff are providing
36 hands-on care related to activities of daily living and nursing-
37 related tasks, as well as care planning. The legislature intends to
38 increase the minimum staffing standard to 4.1 hours per resident day
39 of direct care, but the effective date of a standard higher than 3.4

1 hours per resident day of direct care will be identified if and only
2 if funding is provided explicitly for an increase of the minimum
3 staffing standard for direct care.

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

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

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

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

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

8 (iii) Any geriatric behavioral health worker holding less than a
9 master's degree in social work must be directly supervised by an
10 employee who has a master's degree in social work or a registered
11 nurse.

12 (d) The department shall establish a limited exception to the 3.4
13 HPRD staffing requirement for facilities demonstrating a good faith
14 effort to hire and retain staff. The department's authority to grant
15 exceptions to the 3.4 HPRD minimum staffing requirement expires June
16 30, 2018.

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

20 (b) The department shall establish a limited exception process to
21 facilities that can demonstrate a good faith effort to hire a
22 registered nurse for the last eight hours of required coverage per
23 day. In granting an exception, the department may consider wages and
24 benefits offered and the availability of registered nurses in the
25 particular geographic area. A one-year exception may be granted and
26 may be renewable for up to three consecutive years; however, the
27 department may limit the admission of new residents, based on medical
28 conditions or complexities, when a registered nurse is not on-site
29 and readily available.

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

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

38 Unless the context clearly requires otherwise, the definitions in
39 this section apply throughout this chapter.

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

3 (2) "Facility" refers to a nursing home as defined in RCW
4 18.51.010.

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

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

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

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

16 (7) "Physician" means a person practicing pursuant to chapter
17 18.57 or 18.71 RCW, including, but not limited to, a physician
18 employed by the facility as provided in chapter 18.51 RCW.

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

21 (9) "Qualified therapist" means:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 Unless the context clearly requires otherwise, the definitions in
16 this section apply throughout this chapter.

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

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

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

37 (4) "Audit" or "department audit" means an examination of the
38 records of a nursing facility participating in the medicaid payment
39 system, including but not limited to: The contractor's financial and

1 statistical records, cost reports and all supporting documentation
2 and schedules, receivables, and resident trust funds, to be performed
3 as deemed necessary by the department and according to department
4 rule.

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

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

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

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

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

21 ~~(10))~~ (10) "Contractor" means a person or entity licensed under
22 chapter 18.51 RCW to operate a medicare and medicaid certified
23 nursing facility, responsible for operational decisions, and
24 contracting with the department to provide services to medicaid
25 recipients residing in the facility.

26 ~~((11))~~ (11) "Default case" means no initial assessment has been
27 completed for a resident and transmitted to the department by the
28 cut-off date, or an assessment is otherwise past due for the
29 resident, under state and federal requirements.

30 ~~((12))~~ (12) "Department" means the department of social and
31 health services (DSHS) and its employees.

32 ~~((13))~~ (13) "Depreciation" means the systematic distribution of
33 the cost or other basis of tangible assets, less salvage, over the
34 estimated useful life of the assets.

35 ~~((14))~~ (14) "Direct care" means nursing care and related care
36 provided to nursing facility residents. Therapy care shall not be
37 considered part of direct care.

38 ~~((15))~~ (15) "Direct care supplies" means medical,
39 pharmaceutical, and other supplies required for the direct care of a
40 nursing facility's residents.

1 (~~(16)~~) (15) "Entity" means an individual, partnership,
2 corporation, limited liability company, or any other association of
3 individuals capable of entering enforceable contracts.

4 (~~(17)~~) (16) "Equity" means the net book value of all tangible
5 and intangible assets less the recorded value of all liabilities, as
6 recognized and measured in conformity with generally accepted
7 accounting principles.

8 (~~(18)~~) (17) "Essential community provider" means a facility
9 which is the only nursing facility within a commuting distance radius
10 of at least forty minutes duration, traveling by automobile.

11 (~~(19)~~) (18) "Facility" or "nursing facility" means a nursing
12 home licensed in accordance with chapter 18.51 RCW, excepting nursing
13 homes certified as institutions for mental diseases, or that portion
14 of a multiservice facility licensed as a nursing home, or that
15 portion of a hospital licensed in accordance with chapter 70.41 RCW
16 which operates as a nursing home.

17 (~~(20)~~) (19) "Fair market value" means the replacement cost of
18 an asset less observed physical depreciation on the date for which
19 the market value is being determined.

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

25 (~~(22)~~) (21) "Generally accepted accounting principles" means
26 accounting principles approved by the financial accounting standards
27 board (FASB) or its successor.

28 (~~(23)~~) (22) "Grouper" means a computer software product that
29 groups individual nursing facility residents into case mix
30 classification groups based on specific resident assessment data and
31 computer logic.

32 (~~(24)~~) (23) "High labor-cost county" means an urban county in
33 which the median allowable facility cost per case mix unit is more
34 than ten percent higher than the median allowable facility cost per
35 case mix unit among all other urban counties, excluding that county.

36 (~~(25)~~) (24) "Historical cost" means the actual cost incurred in
37 acquiring and preparing an asset for use, including feasibility
38 studies, architect's fees, and engineering studies.

39 (~~(26)~~) (25) "Home and central office costs" means costs that
40 are incurred in the support and operation of a home and central

1 office. Home and central office costs include centralized services
2 that are performed in support of a nursing facility. The department
3 may exclude from this definition costs that are nonduplicative,
4 documented, ordinary, necessary, and related to the provision of care
5 services to authorized patients.

6 ~~((+27))~~ (26) "Large nonessential community providers" means
7 nonessential community providers with more than sixty licensed beds,
8 regardless of how many beds are set up or in use.

9 ~~((+28))~~ (27) "Lease agreement" means a contract between two
10 parties for the possession and use of real or personal property or
11 assets for a specified period of time in exchange for specified
12 periodic payments. Elimination (due to any cause other than death or
13 divorce) or addition of any party to the contract, expiration, or
14 modification of any lease term in effect on January 1, 1980, or
15 termination of the lease by either party by any means shall
16 constitute a termination of the lease agreement. An extension or
17 renewal of a lease agreement, whether or not pursuant to a renewal
18 provision in the lease agreement, shall be considered a new lease
19 agreement. A strictly formal change in the lease agreement which
20 modifies the method, frequency, or manner in which the lease payments
21 are made, but does not increase the total lease payment obligation of
22 the lessee, shall not be considered modification of a lease term.

23 ~~((+29))~~ (28) "Medical care program" or "medicaid program" means
24 medical assistance, including nursing care, provided under RCW
25 74.09.500 or authorized state medical care services.

26 ~~((+30))~~ (29) "Medical care recipient," "medicaid recipient," or
27 "recipient" means an individual determined eligible by the department
28 for the services provided under chapter 74.09 RCW.

29 ~~((+31))~~ (30) "Minimum data set" means the overall data component
30 of the resident assessment instrument, indicating the strengths,
31 needs, and preferences of an individual nursing facility resident.

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

34 ~~((+33))~~ (32) "Net invested funds" means the net book value of
35 tangible fixed assets employed by a contractor to provide services
36 under the medical care program, including land, buildings, and
37 equipment as recognized and measured in conformity with generally
38 accepted accounting principles.

39 ~~((+34))~~ (33) "Nonurban county" means a county which is not
40 located in a metropolitan statistical area as determined and defined

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

3 ~~((+35+))~~ (34) "Owner" means a sole proprietor, general or limited
4 partners, members of a limited liability company, and beneficial
5 interest holders of five percent or more of a corporation's
6 outstanding stock.

7 ~~((+36+))~~ (35) "Patient day" or "resident day" means a calendar
8 day of care provided to a nursing facility resident, regardless of
9 payment source, which will include the day of admission and exclude
10 the day of discharge; except that, when admission and discharge occur
11 on the same day, one day of care shall be deemed to exist. A
12 "medicaid day" or "recipient day" means a calendar day of care
13 provided to a medicaid recipient determined eligible by the
14 department for services provided under chapter 74.09 RCW, subject to
15 the same conditions regarding admission and discharge applicable to a
16 patient day or resident day of care.

17 ~~((+37+))~~ (36) "Qualified therapist" means:

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

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

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

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

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

30 (f) A respiratory care practitioner certified under chapter 18.89
31 RCW.

32 ~~((+38+))~~ (37) "Rate" or "rate allocation" means the medicaid per-
33 patient-day payment amount for medicaid patients calculated in
34 accordance with the allocation methodology set forth in part E of
35 this chapter.

36 ~~((+39+))~~ (38) "Rebased rate" or "cost-rebased rate" means a
37 facility-specific component rate assigned to a nursing facility for a
38 particular rate period established on desk-reviewed, adjusted costs
39 reported for that facility covering at least six months of a prior

1 calendar year designated as a year to be used for cost-rebasing
2 payment rate allocations under the provisions of this chapter.

3 ~~((40))~~ (39) "Records" means those data supporting all financial
4 statements and cost reports including, but not limited to, all
5 general and subsidiary ledgers, books of original entry, and
6 transaction documentation, however such data are maintained.

7 ~~((41))~~ (40) "Resident assessment instrument," including
8 federally approved modifications for use in this state, means a
9 federally mandated, comprehensive nursing facility resident care
10 planning and assessment tool, consisting of the minimum data set and
11 resident assessment protocols.

12 ~~((42))~~ (41) "Resident assessment protocols" means those
13 components of the resident assessment instrument that use the minimum
14 data set to trigger or flag a resident's potential problems and risk
15 areas.

16 ~~((43))~~ (42) "Resource utilization groups" means a case mix
17 classification system that identifies relative resources needed to
18 care for an individual nursing facility resident.

19 ~~((44))~~ (43) "Secretary" means the secretary of the department
20 of social and health services.

21 ~~((45))~~ (44) "Small nonessential community providers" means
22 nonessential community providers with sixty or fewer licensed beds,
23 regardless of how many beds are set up or in use.

24 ~~((46))~~ (45) "Support services" means food, food preparation,
25 dietary, housekeeping, and laundry services provided to nursing
26 facility residents.

27 ~~((47))~~ (46) "Therapy care" means those services required by a
28 nursing facility resident's comprehensive assessment and plan of
29 care, that are provided by qualified therapists, or support personnel
30 under their supervision, including related costs as designated by the
31 department.

32 ~~((48))~~ (47) "Title XIX" or "medicaid" means the 1965 amendments
33 to the social security act, P.L. 89-07, as amended and the medicaid
34 program administered by the department.

35 ~~((49))~~ (48) "Urban county" means a county which is located in a
36 metropolitan statistical area as determined and defined by the United
37 States office of management and budget or other appropriate agency or
38 office of the federal government.

1 NEW SECTION. **Sec. 5.** 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 and

6 (2) RCW 74.46.807 (Capital authorization—Determination) and 2008
7 c 255 s 2 & 2001 1st sp.s. c 8 s 15.

--- END ---