

CERTIFICATION OF ENROLLMENT
ENGROSSED SUBSTITUTE SENATE BILL 6872

61st Legislature
2010 1st Special Session

Passed by the Senate April 13, 2010
YEAS 30 NAYS 14

President of the Senate

Passed by the House April 13, 2010
YEAS 63 NAYS 34

Speaker of the House of Representatives

Approved

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 6872** as passed by the Senate and the House of Representatives on the dates hereon set forth.

Secretary

FILED

**Secretary of State
State of Washington**

ENGROSSED SUBSTITUTE SENATE BILL 6872

Passed Legislature - 2010 1st Special Session

State of Washington 61st Legislature 2010 Regular Session

By Senate Ways & Means (originally sponsored by Senator Keiser)

READ FIRST TIME 03/09/10.

1 AN ACT Relating to medicaid nursing facility payments; amending RCW
2 74.46.010, 74.46.020, 74.46.431, 74.46.433, 74.46.435, 74.46.437,
3 74.46.439, 74.46.475, 74.46.485, 74.46.496, 74.46.501, 74.46.506,
4 74.46.508, 74.46.511, 74.46.515, 74.46.521, 74.46.835, and 74.46.800;
5 adding new sections to chapter 74.46 RCW; repealing RCW 74.46.030,
6 74.46.040, 74.46.050, 74.46.060, 74.46.080, 74.46.090, 74.46.100,
7 74.46.155, 74.46.165, 74.46.190, 74.46.200, 74.46.220, 74.46.230,
8 74.46.240, 74.46.250, 74.46.270, 74.46.280, 74.46.290, 74.46.300,
9 74.46.310, 74.46.320, 74.46.330, 74.46.340, 74.46.350, 74.46.360,
10 74.46.370, 74.46.380, 74.46.390, 74.46.410, 74.46.445, 74.46.533,
11 74.46.600, 74.46.610, 74.46.620, 74.46.625, 74.46.630, 74.46.640,
12 74.46.650, 74.46.660, 74.46.680, 74.46.690, 74.46.700, 74.46.711,
13 74.46.770, 74.46.780, 74.46.790, 74.46.820, 74.46.900, 74.46.901,
14 74.46.902, 74.46.905, 74.46.906, and 74.46.433; providing effective
15 dates; and declaring an emergency.

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

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

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

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

10 (3) The legislature finds that the medicaid nursing facility rates
11 calculated under this chapter provide sufficient reimbursement to
12 efficient and economically operating facilities and bear a reasonable
13 relationship to costs.

14 **Sec. 2.** RCW 74.46.020 and 2010 c 94 s 29 are each amended to read
15 as follows:

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

18 ~~(1) ("Accrual method of accounting" means a method of accounting~~
19 ~~in which revenues are reported in the period when they are earned,~~
20 ~~regardless of when they are collected, and expenses are reported in the~~
21 ~~period in which they are incurred, regardless of when they are paid.~~

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

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

1 within five years of the date of sale shall not be considered as an
2 arm's-length transaction for purposes of this chapter.

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

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

12 ~~((6) "Bad debts" means amounts considered to be uncollectible from
13 accounts and notes receivable.~~

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

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

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

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

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

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

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

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

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

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

37 ~~except that, any person who acquires an ownership interest or power
38 specified in (c)(i), (ii), or (iii) of this subsection with the purpose~~

1 ~~or effect of changing or influencing the control of the contractor, or~~
2 ~~in connection with or as a participant in any transaction having such~~
3 ~~purpose or effect, immediately upon such acquisition shall be deemed to~~
4 ~~be the beneficial owner of the ownership interest which may be acquired~~
5 ~~through the exercise or conversion of such ownership interest or power;~~

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

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

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

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

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

26 ~~(8))~~ (5) "Capitalization" means the recording of an expenditure as
27 an asset.

28 ~~((9))~~ (6) "Case mix" means a measure of the intensity of care and
29 services needed by the residents of a nursing facility or a group of
30 residents in the facility.

31 ~~((10))~~ (7) "Case mix index" means a number representing the
32 average case mix of a nursing facility.

33 ~~((11))~~ (8) "Case mix weight" means a numeric score that
34 identifies the relative resources used by a particular group of a
35 nursing facility's residents.

36 ~~((12))~~ (9) "Certificate of capital authorization" means a
37 certification from the department for an allocation from the biennial
38 capital financing authorization for all new or replacement building

1 construction, or for major renovation projects, receiving a certificate
2 of need or a certificate of need exemption under chapter 70.38 RCW
3 after July 1, 2001.

4 ~~((+13))~~ (10) "Contractor" means a person or entity licensed under
5 chapter 18.51 RCW to operate a medicare and medicaid certified nursing
6 facility, responsible for operational decisions, and contracting with
7 the department to provide services to medicaid recipients residing in
8 the facility.

9 ~~((+14))~~ (11) "Default case" means no initial assessment has been
10 completed for a resident and transmitted to the department by the
11 cut-off date, or an assessment is otherwise past due for the resident,
12 under state and federal requirements.

13 ~~((+15))~~ (12) "Department" means the department of social and
14 health services (DSHS) and its employees.

15 ~~((+16))~~ (13) "Depreciation" means the systematic distribution of
16 the cost or other basis of tangible assets, less salvage, over the
17 estimated useful life of the assets.

18 ~~((+17))~~ (14) "Direct care" means nursing care and related care
19 provided to nursing facility residents. Therapy care shall not be
20 considered part of direct care.

21 ~~((+18))~~ (15) "Direct care supplies" means medical, pharmaceutical,
22 and other supplies required for the direct care of a nursing facility's
23 residents.

24 ~~((+19))~~ (16) "Entity" means an individual, partnership,
25 corporation, limited liability company, or any other association of
26 individuals capable of entering enforceable contracts.

27 ~~((+20))~~ (17) "Equity" means the net book value of all tangible and
28 intangible assets less the recorded value of all liabilities, as
29 recognized and measured in conformity with generally accepted
30 accounting principles.

31 ~~((+21))~~ (18) "Essential community provider" means a facility which
32 is the only nursing facility within a commuting distance radius of at
33 least forty minutes duration, traveling by automobile.

34 ~~((+22))~~ (19) "Facility" or "nursing facility" means a nursing home
35 licensed in accordance with chapter 18.51 RCW, excepting nursing homes
36 certified as institutions for mental diseases, or that portion of a
37 multiservice facility licensed as a nursing home, or that portion of a

1 hospital licensed in accordance with chapter 70.41 RCW which operates
2 as a nursing home.

3 ~~((+23))~~ (20) "Fair market value" means the replacement cost of an
4 asset less observed physical depreciation on the date for which the
5 market value is being determined.

6 ~~((+24))~~ (21) "Financial statements" means statements prepared and
7 presented in conformity with generally accepted accounting principles
8 including, but not limited to, balance sheet, statement of operations,
9 statement of changes in financial position, and related notes.

10 ~~((+25))~~ (22) "Generally accepted accounting principles" means
11 accounting principles approved by the financial accounting standards
12 board (FASB) or its successor.

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

17 ~~(+27))~~ (23) "Grouper" means a computer software product that groups
18 individual nursing facility residents into case mix classification
19 groups based on specific resident assessment data and computer logic.

20 ~~((+28))~~ (24) "High labor-cost county" means an urban county in
21 which the median allowable facility cost per case mix unit is more than
22 ten percent higher than the median allowable facility cost per case mix
23 unit among all other urban counties, excluding that county.

24 ~~((+29))~~ (25) "Historical cost" means the actual cost incurred in
25 acquiring and preparing an asset for use, including feasibility
26 studies, architect's fees, and engineering studies.

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

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

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

1 ~~(33)~~) (27) "Large nonessential community providers" means
2 nonessential community providers with more than sixty licensed beds,
3 regardless of how many beds are set up or in use.

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

18 ~~((34))~~) (29) "Medical care program" or "medicaid program" means
19 medical assistance, including nursing care, provided under RCW
20 74.09.500 or authorized state medical care services.

21 ~~((35))~~) (30) "Medical care recipient," "medicaid recipient," or
22 "recipient" means an individual determined eligible by the department
23 for the services provided under chapter 74.09 RCW.

24 ~~((36))~~) (31) "Minimum data set" means the overall data component
25 of the resident assessment instrument, indicating the strengths, needs,
26 and preferences of an individual nursing facility resident.

27 ~~((37))~~) (32) "Net book value" means the historical cost of an
28 asset less accumulated depreciation.

29 ~~((38))~~) (33) "Net invested funds" means the net book value of
30 tangible fixed assets employed by a contractor to provide services
31 under the medical care program, including land, buildings, and
32 equipment as recognized and measured in conformity with generally
33 accepted accounting principles.

34 ~~((39))~~) (34) "Nonurban county" means a county which is not located
35 in a metropolitan statistical area as determined and defined by the
36 United States office of management and budget or other appropriate
37 agency or office of the federal government.

1 ~~((40) "Operating lease" means a lease under which rental or lease~~
2 ~~expenses are included in current expenses in accordance with generally~~
3 ~~accepted accounting principles.~~

4 ~~(41))~~ (35) "Owner" means a sole proprietor, general or limited
5 partners, members of a limited liability company, and beneficial
6 interest holders of five percent or more of a corporation's outstanding
7 stock.

8 ~~((42) "Ownership interest" means all interests beneficially owned~~
9 ~~by a person, calculated in the aggregate, regardless of the form which~~
10 ~~such beneficial ownership takes.~~

11 ~~(43))~~ (36) "Patient day" or "resident day" means a calendar day of
12 care provided to a nursing facility resident, regardless of payment
13 source, which will include the day of admission and exclude the day of
14 discharge; except that, when admission and discharge occur on the same
15 day, one day of care shall be deemed to exist. A "medicaid day" or
16 "recipient day" means a calendar day of care provided to a medicaid
17 recipient determined eligible by the department for services provided
18 under chapter 74.09 RCW, subject to the same conditions regarding
19 admission and discharge applicable to a patient day or resident day of
20 care.

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

31 ~~(45))~~ (37) "Qualified therapist" means:

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

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

37 (c) A speech pathologist who is eligible for a certificate of

1 clinical competence in speech pathology or who has the equivalent
2 education and clinical experience;

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

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

7 (f) A respiratory care practitioner certified under chapter 18.89
8 RCW.

9 ~~((46))~~ (38) "Rate" or "rate allocation" means the medicaid per-
10 patient-day payment amount for medicaid patients calculated in
11 accordance with the allocation methodology set forth in part E of this
12 chapter.

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

16 ~~(48))~~ (39) "Rebased rate" or "cost-rebased rate" means a facility-
17 specific component rate assigned to a nursing facility for a particular
18 rate period established on desk-reviewed, adjusted costs reported for
19 that facility covering at least six months of a prior calendar year
20 designated as a year to be used for cost-rebasing payment rate
21 allocations under the provisions of this chapter.

22 ~~((49))~~ (40) "Records" means those data supporting all financial
23 statements and cost reports including, but not limited to, all general
24 and subsidiary ledgers, books of original entry, and transaction
25 documentation, however such data are maintained.

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

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

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

36 ~~(51) "Related care" means only those services that are directly
37 related to providing direct care to nursing facility residents. These~~

1 ~~services include, but are not limited to, nursing direction and~~
2 ~~supervision, medical direction, medical records, pharmacy services,~~
3 ~~activities, and social services.~~

4 ~~(+52+))~~ (41) "Resident assessment instrument," including federally
5 approved modifications for use in this state, means a federally
6 mandated, comprehensive nursing facility resident care planning and
7 assessment tool, consisting of the minimum data set and resident
8 assessment protocols.

9 ~~((+53+))~~ (42) "Resident assessment protocols" means those
10 components of the resident assessment instrument that use the minimum
11 data set to trigger or flag a resident's potential problems and risk
12 areas.

13 ~~((+54+))~~ (43) "Resource utilization groups" means a case mix
14 classification system that identifies relative resources needed to care
15 for an individual nursing facility resident.

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

19 ~~(+56+))~~ (44) "Secretary" means the secretary of the department of
20 social and health services.

21 ~~((+57+))~~ (45) "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) "Support services" means food, food preparation, dietary,
25 housekeeping, and laundry services provided to nursing facility
26 residents.

27 ~~((+58+))~~ (47) "Therapy care" means those services required by a
28 nursing facility resident's comprehensive assessment and plan of care,
29 that are provided by qualified therapists, or support personnel under
30 their supervision, including related costs as designated by the
31 department.

32 ~~((+59+))~~ (48) "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 ~~((+60+))~~ (49) "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 ~~((61) "Vital local provider" means a facility that meets the~~
2 ~~following qualifications:~~

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

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

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

10 ~~The definition of "vital local provider" shall expire, and have no~~
11 ~~force or effect, after June 30, 2007. After that date, no facility's~~
12 ~~payments under this chapter shall in any way be affected by its prior~~
13 ~~determination or recognition as a vital local provider.))~~

14 **Sec. 3.** RCW 74.46.431 and 2009 c 570 s 1 are each amended to read
15 as follows:

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

23 (2) Component rate allocations in therapy care~~((,))~~ and support
24 services~~((, variable return, operations, property, and financing~~
25 allowance for essential community providers as defined in this
26 chapter)) for all facilities shall be based upon a minimum facility
27 occupancy of eighty-five percent of licensed beds, regardless of how
28 many beds are set up or in use. ~~((For all facilities other than~~
29 ~~essential community providers, effective July 1, 2001, component rate~~
30 ~~allocations in direct care, therapy care, support services, and~~
31 ~~variable return shall be based upon a minimum facility occupancy of~~
32 ~~eighty five percent of licensed beds. For all facilities other than~~
33 ~~essential community providers, effective July 1, 2002, the component~~
34 ~~rate allocations in operations, property, and financing allowance shall~~
35 ~~be based upon a minimum facility occupancy of ninety percent of~~
36 ~~licensed beds, regardless of how many beds are set up or in use.))~~
37 Component rate allocations in operations, property, and financing

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

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

34 (4)(a) Direct care component rate allocations shall be established
35 using adjusted cost report data covering at least six months.
36 (~~Adjusted cost report data from 1996 will be used for October 1, 1998,~~
37 ~~through June 30, 2001, direct care component rate allocations; adjusted~~
38 ~~cost report data from 1999 will be used for July 1, 2001, through June~~

1 ~~30, 2006, direct care component rate allocations. Adjusted cost report~~
2 ~~data from 2003 will be used for July 1, 2006, through June 30, 2007,~~
3 ~~direct care component rate allocations. Adjusted cost report data from~~
4 ~~2005 will be used for July 1, 2007, through June 30, 2009, direct care~~
5 ~~component rate allocations.)) Effective July 1, 2009, the direct care~~
6 ~~component rate allocation shall be rebased ((biennially, and thereafter~~
7 ~~for each odd-numbered year beginning July 1st)), using the adjusted~~
8 ~~cost report data for the calendar year two years immediately preceding~~
9 ~~the rate rebase period, so that adjusted cost report data for calendar~~
10 ~~year 2007 is used for July 1, 2009, through June 30, ((2011)) 2012.~~
11 Beginning July 1, 2012, the direct care component rate allocation shall
12 be rebased biennially during every even-numbered year thereafter using
13 adjusted cost report data from two years prior to the rebase period, so
14 adjusted cost report data for calendar year 2010 is used for July 1,
15 2012, through June 30, 2014, and so forth.

16 (b) ~~((Direct care component rate allocations based on 1996 cost~~
17 ~~report data shall be adjusted annually for economic trends and~~
18 ~~conditions by a factor or factors defined in the biennial~~
19 ~~appropriations act. A different economic trends and conditions~~
20 ~~adjustment factor or factors may be defined in the biennial~~
21 ~~appropriations act for facilities whose direct care component rate is~~
22 ~~set equal to their adjusted June 30, 1998, rate, as provided in RCW~~
23 ~~74.46.506(5)(i)).~~

24 (c) ~~Direct care component rate allocations based on 1999 cost~~
25 ~~report data shall be adjusted annually for economic trends and~~
26 ~~conditions by a factor or factors defined in the biennial~~
27 ~~appropriations act. A different economic trends and conditions~~
28 ~~adjustment factor or factors may be defined in the biennial~~
29 ~~appropriations act for facilities whose direct care component rate is~~
30 ~~set equal to their adjusted June 30, 1998, rate, as provided in RCW~~
31 ~~74.46.506(5)(i)).~~

32 (d) ~~Direct care component rate allocations based on 2003 cost~~
33 ~~report data shall be adjusted annually for economic trends and~~
34 ~~conditions by a factor or factors defined in the biennial~~
35 ~~appropriations act. A different economic trends and conditions~~
36 ~~adjustment factor or factors may be defined in the biennial~~
37 ~~appropriations act for facilities whose direct care component rate is~~

1 ~~set equal to their adjusted June 30, 2006, rate, as provided in RCW~~
2 ~~74.46.506(5)(i).~~

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

17 (5)(a) Therapy care component rate allocations shall be established
18 using adjusted cost report data covering at least six months.
19 ~~((Adjusted cost report data from 1996 will be used for October 1, 1998,~~
20 ~~through June 30, 2001, therapy care component rate allocations;~~
21 ~~adjusted cost report data from 1999 will be used for July 1, 2001,~~
22 ~~through June 30, 2005, therapy care component rate allocations.~~
23 ~~Adjusted cost report data from 1999 will continue to be used for July~~
24 ~~1, 2005, through June 30, 2007, therapy care component rate~~
25 ~~allocations. Adjusted cost report data from 2005 will be used for July~~
26 ~~1, 2007, through June 30, 2009, therapy care component rate~~
27 ~~allocations.))~~ Effective July 1, 2009, ~~((and thereafter for each~~
28 ~~odd-numbered year beginning July 1st,))~~ the therapy care component rate
29 allocation shall be cost rebased ~~((biennially, using the adjusted cost~~
30 ~~report data for the calendar year two years immediately preceding the~~
31 ~~rate rebase period)),~~ so that adjusted cost report data for calendar
32 year 2007 is used for July 1, 2009, through June 30, ~~((2011))~~ 2012.
33 Beginning July 1, 2012, the therapy care component rate allocation
34 shall be rebased biennially during every even-numbered year thereafter
35 using adjusted cost report data from two years prior to the rebase
36 period, so adjusted cost report data for calendar year 2010 is used for
37 July 1, 2012, through June 30, 2014, and so forth.

1 (b) Therapy care component rate allocations established in
2 accordance with this chapter shall be adjusted annually for economic
3 trends and conditions by a factor or factors defined in the biennial
4 appropriations act. The economic trends and conditions factor or
5 factors defined in the biennial appropriations act shall not be
6 compounded with the economic trends and conditions factor or factors
7 defined in any other biennial appropriations acts before applying it to
8 the therapy care component rate allocation established in accordance
9 with this chapter. When no economic trends and conditions factor or
10 factors for either fiscal year are defined in a biennial appropriations
11 act, no economic trends and conditions factor or factors defined in any
12 earlier biennial appropriations act shall be applied solely or
13 compounded to the therapy care component rate allocation established in
14 accordance with this chapter.

15 (6)(a) Support services component rate allocations shall be
16 established using adjusted cost report data covering at least six
17 months. ~~((Adjusted cost report data from 1996 shall be used for
18 October 1, 1998, through June 30, 2001, support services component rate
19 allocations; adjusted cost report data from 1999 shall be used for July
20 1, 2001, through June 30, 2005, support services component rate
21 allocations. Adjusted cost report data from 1999 will continue to be
22 used for July 1, 2005, through June 30, 2007, support services
23 component rate allocations. Adjusted cost report data from 2005 will
24 be used for July 1, 2007, through June 30, 2009, support services
25 component rate allocations.))~~ Effective July 1, 2009, ~~((and thereafter
26 for each odd-numbered year beginning July 1st,))~~ the support services
27 component rate allocation shall be cost rebased ~~((biennially, using the
28 adjusted cost report data for the calendar year two years immediately
29 preceding the rate rebase period))~~, so that adjusted cost report data
30 for calendar year 2007 is used for July 1, 2009, through June 30,
31 ~~((2011))~~ 2012. Beginning July 1, 2012, the support services component
32 rate allocation shall be rebased biennially during every even-numbered
33 year thereafter using adjusted cost report data from two years prior to
34 the rebase period, so adjusted cost report data for calendar year 2010
35 is used for July 1, 2012, through June 30, 2014, and so forth.

36 (b) Support services component rate allocations established in
37 accordance with this chapter shall be adjusted annually for economic
38 trends and conditions by a factor or factors defined in the biennial

1 appropriations act. The economic trends and conditions factor or
2 factors defined in the biennial appropriations act shall not be
3 compounded with the economic trends and conditions factor or factors
4 defined in any other biennial appropriations acts before applying it to
5 the support services component rate allocation established in
6 accordance with this chapter. When no economic trends and conditions
7 factor or factors for either fiscal year are defined in a biennial
8 appropriations act, no economic trends and conditions factor or factors
9 defined in any earlier biennial appropriations act shall be applied
10 solely or compounded to the support services component rate allocation
11 established in accordance with this chapter.

12 (7)(a) Operations component rate allocations shall be established
13 using adjusted cost report data covering at least six months.
14 (~~Adjusted cost report data from 1996 shall be used for October 1,~~
15 ~~1998, through June 30, 2001, operations component rate allocations;~~
16 ~~adjusted cost report data from 1999 shall be used for July 1, 2001,~~
17 ~~through June 30, 2006, operations component rate allocations. Adjusted~~
18 ~~cost report data from 2003 will be used for July 1, 2006, through June~~
19 ~~30, 2007, operations component rate allocations. Adjusted cost report~~
20 ~~data from 2005 will be used for July 1, 2007, through June 30, 2009,~~
21 ~~operations component rate allocations.)) Effective July 1, 2009, ((and~~
22 ~~thereafter for each odd-numbered year beginning July 1st,)) the
23 operations component rate allocation shall be cost rebased
24 ((biennially, using the adjusted cost report data for the calendar year
25 two years immediately preceding the rate rebase period)), so that
26 adjusted cost report data for calendar year 2007 is used for July 1,
27 2009, through June 30, ((2011)) 2012. Beginning July 1, 2012, the
28 operations care component rate allocation shall be rebased biennially
29 during every even-numbered year thereafter using adjusted cost report
30 data from two years prior to the rebase period, so adjusted cost report
31 data for calendar year 2010 is used for July 1, 2012, through June 30,
32 2014, and so forth.~~

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

1 defined in any other biennial appropriations acts before applying it to
2 the operations component rate allocation established in accordance with
3 this chapter. When no economic trends and conditions factor or factors
4 for either fiscal year are defined in a biennial appropriations act, no
5 economic trends and conditions factor or factors defined in any earlier
6 biennial appropriations act shall be applied solely or compounded to
7 the operations component rate allocation established in accordance with
8 this chapter. ~~((A different economic trends and conditions adjustment
9 factor or factors may be defined in the biennial appropriations act for
10 facilities whose operations component rate is set equal to their
11 adjusted June 30, 2006, rate, as provided in RCW 74.46.521(4)).~~

12 ~~((8) For July 1, 1998, through September 30, 1998, a facility's
13 property and return on investment component rates shall be the
14 facility's June 30, 1998, property and return on investment component
15 rates, without increase. For October 1, 1998, through June 30, 1999,
16 a facility's property and return on investment component rates shall be
17 rebased utilizing 1997 adjusted cost report data covering at least six
18 months of data.~~

19 ~~((9))~~ (8) Total payment rates under the nursing facility medicaid
20 payment system shall not exceed facility rates charged to the general
21 public for comparable services.

22 ~~((10) Medicaid contractors shall pay to all facility staff a
23 minimum wage of the greater of the state minimum wage or the federal
24 minimum wage.~~

25 ~~((11))~~ (9) The department shall establish in rule procedures,
26 principles, and conditions for determining component rate allocations
27 for facilities in circumstances not directly addressed by this chapter,
28 including but not limited to: ~~((The need to prorate))~~ Inflation
29 adjustments for partial-period cost report data, newly constructed
30 facilities, existing facilities entering the medicaid program for the
31 first time or after a period of absence from the program, existing
32 facilities with expanded new bed capacity, existing medicaid facilities
33 following a change of ownership of the nursing facility business,
34 ~~((facilities banking beds or converting beds back into service,))~~
35 facilities temporarily reducing the number of set-up beds during a
36 remodel, facilities having less than six months of either resident
37 assessment, cost report data, or both, under the current contractor
38 prior to rate setting, and other circumstances.

1 ~~((12))~~ (10) The department shall establish in rule procedures,
2 principles, and conditions, including necessary threshold costs, for
3 adjusting rates to reflect capital improvements or new requirements
4 imposed by the department or the federal government. Any such rate
5 adjustments are subject to the provisions of RCW 74.46.421.

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

24 ~~(14))~~ (11) Effective July 1, 2010, there shall be no rate
25 adjustment for facilities with banked beds. For purposes of
26 calculating minimum occupancy, licensed beds include any beds banked
27 under chapter 70.38 RCW.

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

36 **Sec. 4.** RCW 74.46.433 and 2006 c 258 s 3 are each amended to read
37 as follows:

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

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

8 (b) To calculate the array of facilities ~~((for the July 1, 2001,~~
9 ~~rate setting))~~, the department, without using peer groups, shall first
10 rank all facilities in numerical order from highest to lowest according
11 to each facility's examined and documented, but unlidged, combined
12 direct care, therapy care, support services, and operations per
13 resident day cost from the ~~((1999 cost report period))~~ applicable cost
14 report period specified in RCW 74.46.431(4)(a). However, before being
15 combined with other per resident day costs and ranked, a facility's
16 direct care cost per resident day shall be adjusted to reflect its
17 facility average case mix index, to be averaged from the four calendar
18 quarters of ~~((1999))~~ the cost report period identified in RCW
19 74.46.431(4)(a), weighted by the facility's resident days from each
20 quarter, under RCW 74.46.501~~((+7))~~ (6)(b)((+ii)). The array shall
21 then be divided into four quartiles, each containing, as nearly as
22 possible, an equal number of facilities, and four percent shall be
23 assigned to facilities in the lowest quartile, three percent to
24 facilities in the next lowest quartile, two percent to facilities in
25 the next highest quartile, and one percent to facilities in the highest
26 quartile.

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

32 (d) ~~((Effective July 1, 2001, if a facility's examined and~~
33 ~~documented direct care cost per resident day for the preceding report~~
34 ~~year is lower than its average direct care component rate weighted by~~
35 ~~medicaid resident days for the same year, the facility's direct care~~
36 ~~cost shall be substituted for its July 1, 2001, direct care component~~
37 ~~rate, and its variable return component rate shall be determined or~~
38 ~~adjusted each July 1st by multiplying the facility's assigned~~

1 ~~percentage by the sum of the facility's July 1, 2001, therapy care,~~
2 ~~support services, and operations component rates, and its direct care~~
3 ~~cost per resident day for the preceding year.~~

4 ~~(e) Effective July 1, 2006,)~~ The variable return component rate
5 allocation for each facility shall be thirty percent of the facility's
6 June 30, 2006, variable return component rate allocation.

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

10 **Sec. 5.** RCW 74.46.435 and 2001 1st sp.s. c 8 s 7 are each amended
11 to read as follows:

12 (1) ~~((Effective July 1, 2001,))~~ The property component rate
13 allocation for each facility shall be determined by dividing the sum of
14 the reported allowable prior period actual depreciation, subject to
15 ~~((RCW 74.46.310 through 74.46.380))~~ department rule, adjusted for any
16 capitalized additions or replacements approved by the department, and
17 the retained savings from such cost center, by the greater of a
18 facility's total resident days ~~((for the facility))~~ in the prior period
19 or resident days as calculated on eighty-five percent facility
20 occupancy for essential community providers, ninety percent occupancy
21 for small nonessential community providers, or ninety-two percent
22 facility occupancy for large nonessential community providers.
23 ~~((Effective July 1, 2002, the property component rate allocation for~~
24 ~~all facilities, except essential community providers, shall be set by~~
25 ~~using the greater of a facility's total resident days from the most~~
26 ~~recent cost report period or resident days calculated at ninety percent~~
27 ~~facility occupancy.))~~ If a capitalized addition or retirement of an
28 asset will result in a different licensed bed capacity during the
29 ensuing period, the prior period total resident days used in computing
30 the property component rate shall be adjusted to anticipated resident
31 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) ((Effective July 1, 2001, for the purpose of calculating a~~
4 ~~nursing facility's property component rate, if a contractor has elected~~
5 ~~to bank licensed beds prior to April 1, 2001, or elects to convert~~
6 ~~banked beds to active service at any time, under chapter 70.38 RCW, the~~
7 ~~department shall use the facility's new licensed bed capacity to~~
8 ~~recalculate minimum occupancy for rate setting and revise the property~~
9 ~~component rate, as needed, effective as of the date the beds are banked~~
10 ~~or converted to active service. However, in no case shall the~~
11 ~~department use less than eighty five percent occupancy of the~~
12 ~~facility's licensed bed capacity after banking or conversion.~~
13 ~~Effective July 1, 2002, in no case, other than essential community~~
14 ~~providers, shall the department use less than ninety percent occupancy~~
15 ~~of the facility's licensed bed capacity after conversion.~~

16 ~~(5))~~ The property component rate allocations calculated in
17 accordance with this section shall be adjusted to the extent necessary
18 to comply with RCW 74.46.421.

19 **Sec. 6.** RCW 74.46.437 and 2001 1st sp.s. c 8 s 8 are each amended
20 to read as follows:

21 ~~(1) ((Beginning July 1, 1999,))~~ The department shall establish for
22 each medicaid nursing facility a financing allowance component rate
23 allocation. The financing allowance component rate shall be rebased
24 annually, effective July 1st, in accordance with the provisions of this
25 section and this chapter.

26 ~~(2) ((Effective July 1, 2001,))~~ The financing allowance shall be
27 determined by multiplying the net invested funds of each facility by
28 ~~((-.10))~~ 0.04, and dividing by the greater of a nursing facility's total
29 resident days from the most recent cost report period or resident days
30 calculated on eighty-five percent facility occupancy for essential
31 community providers, ninety percent facility occupancy for small
32 nonessential community providers, or ninety-two percent occupancy for
33 large nonessential community providers. ~~((Effective July 1, 2002, the~~
34 ~~financing allowance component rate allocation for all facilities, other~~
35 ~~than essential community providers, shall be set by using the greater~~
36 ~~of a facility's total resident days from the most recent cost report~~
37 ~~period or resident days calculated at ninety percent facility~~

1 ~~occupancy.))~~ However, assets acquired on or after May 17, 1999, shall
2 be grouped in a separate financing allowance calculation that shall be
3 multiplied by ~~((-.085))~~ 0.04. The financing allowance factor of
4 ~~((-.085))~~ 0.04 shall ~~((not))~~ be applied to the net invested funds
5 pertaining to new construction or major renovations receiving
6 certificate of need approval or an exemption from certificate of need
7 requirements under chapter 70.38 RCW, or to working drawings that have
8 been submitted to the department of health for construction review
9 approval, prior to May 17, 1999. If a capitalized addition,
10 renovation, replacement, or retirement of an asset will result in a
11 different licensed bed capacity during the ensuing period, the prior
12 period total resident days used in computing the financing allowance
13 shall be adjusted to the greater of the anticipated resident day level
14 or eighty-five percent of the new licensed bed capacity for essential
15 community providers, ninety percent of the new licensed bed capacity
16 for small nonessential community providers, or ninety-two percent of
17 the new licensed bed capacity for large nonessential community
18 providers. ~~((Effective July 1, 2002, for all facilities, other than~~
19 ~~essential community providers, the total resident days used to compute~~
20 ~~the financing allowance after a capitalized addition, renovation,~~
21 ~~replacement, or retirement of an asset shall be set by using the~~
22 ~~greater of a facility's total resident days from the most recent cost~~
23 ~~report period or resident days calculated at ninety percent facility~~
24 ~~occupancy.))~~

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

1 facilities where the net invested funds are unknown or the contractor
2 is unable to provide necessary information to determine net invested
3 funds, the secretary shall have the authority to determine an amount
4 for net invested funds based on an appraisal conducted according to
5 (~~RCW 74.46.360(1)~~) department rule.

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

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

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

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

33 (a) ~~The financing allowance shall be recomputed substituting the~~
34 ~~fair market value of the assets as of January 1, 1982, as determined by~~
35 ~~the department of general administration through an appraisal~~
36 ~~procedure, less accumulated depreciation on the lessor's assets since~~
37 ~~January 1, 1982, for the net book value of the assets in determining~~

1 net invested funds for the facility. A determination by the department
2 of general administration of fair market value shall be final unless
3 the procedure used to make such a determination is shown to be
4 arbitrary and capricious.

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

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

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

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

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

29 **Sec. 8.** RCW 74.46.475 and 1998 c 322 s 21 are each amended to read
30 as follows:

31 ((+1)) The department shall analyze the submitted cost report or
32 a portion thereof of each contractor for each report period to
33 determine if the information is correct, complete, reported in
34 conformance with department instructions and generally accepted
35 accounting principles, the requirements of this chapter, and such rules
36 as the department may adopt. If the analysis finds that the cost
37 report is incorrect or incomplete, the department may make adjustments

1 to the reported information for purposes of establishing payment rate
2 allocations. A schedule of such adjustments shall be provided to
3 contractors and shall include an explanation for the adjustment and the
4 dollar amount of the adjustment. Adjustments shall be subject to
5 review and appeal as provided in this chapter.

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

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

10 ~~(b) Establishing rates.~~

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

13 **Sec. 9.** RCW 74.46.485 and 2009 c 570 s 2 are each amended to read
14 as follows:

15 (1) The department shall:

16 (a) Employ the resource utilization group III case mix
17 classification methodology. The department shall use the forty-four
18 group index maximizing model for the resource utilization group III
19 grouper version 5.10, but the department may revise or update the
20 classification methodology to reflect advances or refinements in
21 resident assessment or classification, subject to federal requirements;
22 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 ~~((quarterly))~~ semiannual rate settings following the
28 date of minimum data set 3.0 implementation a previously established
29 ~~((quarterly))~~ semiannual case mix adjustment established for the
30 ~~((quarterly))~~ semiannual rate settings that will be used for
31 ~~((quarterly))~~ semiannual case mix calculations in direct care until
32 minimum data set 3.0 is fully implemented. After the department has
33 fully implemented minimum data set 3.0, it must adjust any ~~((quarter))~~
34 semiannual rate setting in which it used the previously established
35 ~~((quarterly))~~ case mix adjustment using the new minimum data set 3.0
36 data.

1 (2) A default case mix group shall be established for cases in
2 which the resident dies or is discharged for any purpose prior to
3 completion of the resident's initial assessment. The default case mix
4 group and case mix weight for these cases shall be designated by the
5 department.

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

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

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

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

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

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

35 (b) Calculate the total weighted minutes for each case mix group in
36 the resource utilization group III classification system by multiplying
37 the wage weight for each worker classification by the average number of

1 minutes that classification of worker spends caring for a resident in
2 that resource utilization group III classification group, and summing
3 the products;

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

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

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

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

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

29 (2)(a) In calculating a facility's two average case mix indexes for
30 each quarter, the department shall include all residents or medicaid
31 residents, as applicable, who were physically in the facility during
32 the quarter in question based on the resident assessment instrument
33 completed by the facility and the requirements and limitations for the
34 instrument's completion and transmission (January 1st through March
35 31st, April 1st through June 30th, July 1st through September 30th, or
36 October 1st through December 31st).

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

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

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

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

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

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

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

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

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

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

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

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

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

36 ~~(7))~~(a) Although the facility average and the medicaid average
37 case mix indexes shall both be calculated quarterly, the cost-rebasing
38 period facility average case mix index will be used throughout the

1 applicable cost-rebasing period in combination with cost report data as
2 specified by RCW 74.46.431 and 74.46.506, to establish a facility's
3 allowable cost per case mix unit. A facility's medicaid average case
4 mix index shall be used to update a nursing facility's direct care
5 component rate (~~(quarterly)~~) semiannually.

6 (b) The facility average case mix index used to establish each
7 nursing facility's direct care component rate shall be based on an
8 average of calendar quarters of the facility's average case mix
9 indexes(~~(-~~

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

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

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

21 (c) The medicaid average case mix index used to update or
22 recalibrate a nursing facility's direct care component rate
23 (~~(quarterly)~~) semiannually shall be from the calendar (~~(quarter)~~) six-
24 month period commencing (~~(six)~~) nine months prior to the effective date
25 of the (~~(quarterly)~~) semiannual rate. For example, (~~(October 1, 1998)~~)
26 July 1, 2010, through December 31, (~~(1998)~~) 2010, direct care component
27 rates shall utilize case mix averages from the (~~(April 1, 1998)~~)
28 October 1, 2009, through (~~(June 30, 1998)~~) March 31, 2010, calendar
29 quarters, and so forth.

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

32 (1) The direct care component rate allocation corresponds to the
33 provision of nursing care for one resident of a nursing facility for
34 one day, including direct care supplies. Therapy services and
35 supplies, which correspond to the therapy care component rate, shall be
36 excluded. The direct care component rate includes elements of case mix

1 determined consistent with the principles of this section and other
2 applicable provisions of this chapter.

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

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

20 (4) Cost report data used in setting direct care component rate
21 allocations shall be for rate periods as specified in RCW
22 74.46.431(4)(a).

23 (5) (~~Beginning October 1, 1998,~~) The department shall rebase each
24 nursing facility's direct care component rate allocation as described
25 in RCW 74.46.431, adjust its direct care component rate allocation for
26 economic trends and conditions as described in RCW 74.46.431, and
27 update its medicaid average case mix index as described in RCW
28 74.46.496 and 74.46.501, consistent with the following:

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

34 (b) Divide each facility's total allowable direct care cost by its
35 adjusted resident days for the same report period, (~~increased if~~
36 ~~necessary to a minimum occupancy of eighty five percent; that is, the~~
37 ~~greater of actual or imputed occupancy at eighty five percent of~~
38 ~~licensed beds,~~) to derive the facility's allowable direct care cost

1 per resident day(~~(. — However, effective July 1, 2006, each facility's~~
2 ~~allowable direct care costs shall be divided by its adjusted resident~~
3 ~~days without application of a minimum occupancy assumption)) ;~~

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

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

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

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

20 ~~((g) Except as provided in (i) of this subsection, from October 1,~~
21 ~~1998, through June 30, 2000, determine each facility's quarterly direct~~
22 ~~care component rate as follows:~~

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

31 ~~(ii) Any facility whose allowable cost per case mix unit is greater~~
32 ~~than one hundred fifteen percent of the peer group median established~~
33 ~~under (f) of this subsection shall be assigned a cost per case mix unit~~
34 ~~equal to one hundred fifteen percent of the peer group median, and~~
35 ~~shall have a direct care component rate allocation equal to the~~
36 ~~facility's assigned cost per case mix unit multiplied by that~~
37 ~~facility's medicaid average case mix index from the applicable quarter~~
38 ~~specified in RCW 74.46.501(7)(c);~~

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

7 ~~(h) Except as provided in (i) of this subsection, from July 1,~~
8 ~~2000, through June 30, 2006, determine each facility's quarterly direct~~
9 ~~care component rate as follows:~~

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

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

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

32 ~~(i)(i) Between October 1, 1998, and June 30, 2000, the department~~
33 ~~shall compare each facility's direct care component rate allocation~~
34 ~~calculated under (g) of this subsection with the facility's nursing~~
35 ~~services component rate in effect on September 30, 1998, less therapy~~
36 ~~costs, plus any exceptional care offsets as reported on the cost~~
37 ~~report, adjusted for economic trends and conditions as provided in RCW~~
38 ~~74.46.431. A facility shall receive the higher of the two rates.~~

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

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

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

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

23 ~~(A) The department shall calculate:~~

24 ~~(I) The sum of each facility's July 1, 2006, direct care component~~
25 ~~rate allocation calculated under (j) of this subsection and July 1,~~
26 ~~2006, operations component rate calculated under RCW 74.46.521; and~~

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

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

33 ~~(C) If the sum calculated under (i)(v)(A)(I) of this subsection is~~
34 ~~greater than or equal to the sum calculated under (i)(v)(A)(II) of this~~
35 ~~subsection, the facility's direct care component rate shall be~~
36 ~~calculated under (j) of this subsection;~~

37 ~~(j) Except as provided in (i) of this subsection, from July 1,~~

1 ~~2006, forward, and for all future rate setting,~~) (f) Determine each
2 facility's ~~((quarterly))~~ semiannual direct care component rate as
3 follows:

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

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

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

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

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

31 ~~((+1+))~~ The department is authorized to increase the direct care
32 component rate allocation calculated under RCW 74.46.506(5) for
33 residents who have unmet exceptional care needs as determined by the
34 department in rule. The department may, by rule, establish criteria,
35 patient categories, and methods of exceptional care payment.

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

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

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

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

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

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

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

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

1 (c) Therapy consulting expenses for all residents.

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

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

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

9 (b) Those located within nonurban counties.

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

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

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

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

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

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

1 department, shall be added to the total allowable one-on-one therapy
2 expense to determine the allowable therapy cost for each therapy type;

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

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

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

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

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

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

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

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

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

36 (b) Set each facility's support services component rate at the
37 lower of the facility's per resident day adjusted support services

1 costs from the applicable cost report period or the adjusted median per
2 resident day support services cost for that facility's peer group,
3 either urban counties or nonurban counties, plus ten percent; and

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

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

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

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

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

31 ~~((Except as provided in subsection (4) of this section,))~~ For
32 all calculations and adjustments in this subsection, the department
33 shall use the greater of the facility's actual occupancy or an imputed
34 occupancy equal to eighty-five percent for essential community
35 providers, ninety percent for small nonessential community providers,
36 or ninety-two percent for large nonessential community providers. To

1 determine each facility's operations component rate the department
2 shall:

3 (a) Array facilities' adjusted general operations costs per
4 adjusted resident day, as determined by dividing each facility's total
5 allowable operations cost by its adjusted resident days for the same
6 report period(~~(, increased if necessary to a minimum occupancy of~~
7 ~~ninety percent; that is, the greater of actual or imputed occupancy at~~
8 ~~ninety percent of licensed beds, for each facility from facilities'~~
9 ~~cost reports from the applicable report year,)) for facilities located
10 within urban counties and for those located within nonurban counties
11 and determine the median adjusted cost for each peer group;~~

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

13 (i) The facility's per resident day adjusted operations costs from
14 the applicable cost report period adjusted if necessary (~~(to a))~~ for
15 minimum occupancy (~~(of eighty five percent of licensed beds before July~~
16 ~~1, 2002, and ninety percent effective July 1, 2002))~~); or

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

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

22 ~~(4)((a) Effective July 1, 2006, through June 30, 2007, for any~~
23 ~~facility whose direct care component rate allocation is set equal to~~
24 ~~its June 30, 2006, direct care component rate allocation, as provided~~
25 ~~in RCW 74.46.506(5), the facility's operations component rate~~
26 ~~allocation shall also be set equal to the facility's June 30, 2006,~~
27 ~~operations component rate allocation.~~

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

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

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

37 (1) Payment for direct care at the pilot nursing facility in King

1 county designed to meet the service needs of residents living with
2 AIDS, as defined in RCW 70.24.017, and as specifically authorized for
3 this purpose under chapter 9, Laws of 1989 1st ex. sess., shall be
4 exempt from case mix methods of rate determination set forth in this
5 chapter and shall be exempt from the direct care metropolitan
6 statistical area peer group cost limitation set forth in this chapter.

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

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

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

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

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

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

29 NEW SECTION. **Sec. 19.** A new section is added to chapter 74.46 RCW
30 to read as follows:

31 The department shall establish, by rule, the procedures,
32 principles, and conditions for the nursing facility medicaid payment
33 system addressed by the following principles:

34 (1) The department must receive complete, annual reporting of all
35 costs and the financial condition of each contractor, prepared and
36 presented in a standardized manner. The department shall establish, by

1 rule, due dates, requirements for cost report completion, actions
2 required for improperly completed or late cost reports, fines for any
3 statutory or regulatory noncompliance, retention requirements, and
4 public disclosure requirements.

5 (2) The department shall examine all cost reports to determine
6 whether the information is correct, complete, and reported in
7 compliance with this chapter, department rules and instructions, and
8 generally accepted accounting principles.

9 (3) Each contractor must establish and maintain, as a service to
10 the resident, a bookkeeping system incorporated into the business
11 records for all resident funds entrusted to the contractor and received
12 by the contractor for the resident. The department shall adopt rules
13 to ensure that resident personal funds handled by the contractor are
14 maintained by each contractor in a manner that is, at a minimum,
15 consistent with federal requirements.

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

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

22 (6) The department shall establish a settlement process in order to
23 reconcile medicaid resident days to billed days and medicaid payments
24 for the preceding calendar year. The settlement process shall ensure
25 that any savings in the direct care or therapy care component rates be
26 shifted only between direct care and therapy care component rates, and
27 shall not be shifted into any other rate components.

28 (7) The department shall define and identify allowable and
29 unallowable costs.

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

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

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

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

7 (12) The department shall have authority to adopt, amend, and
8 rescind such administrative rules and definitions as it deems necessary
9 to carry out the policies and purposes of this chapter.

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

12 The department shall establish, by rule, the procedures,
13 principles, and conditions for a pay-for-performance supplemental
14 payment structure that provides payment add-ons for high performing
15 facilities. To the extent that funds are appropriated for this
16 purpose, the pay-for-performance structure will include a one percent
17 reduction in payments to facilities with exceptionally high direct care
18 staff turnover, and a method by which the funding that is not paid to
19 these facilities is then used to provide a supplemental payment to
20 facilities with lower direct care staff turnover.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 (41) RCW 74.46.690 (Change of ownership--Final reports--Settlement)
2 and 1998 c 322 s 39, 1995 1st sp.s. c 18 s 113, 1985 c 361 s 3, 1983
3 1st ex.s. c 67 s 36, & 1980 c 177 s 69;

4 (42) RCW 74.46.700 (Resident personal funds--Records--Rules) and
5 1991 sp.s. c 8 s 19 & 1980 c 177 s 70;

6 (43) RCW 74.46.711 (Resident personal funds--Conveyance upon death
7 of resident) and 2001 1st sp.s. c 8 s 14 & 1995 1st sp.s. c 18 s 69;

8 (44) RCW 74.46.770 (Contractor appeals--Challenges of laws, rules,
9 or contract provisions--Challenge based on federal law) and 1998 c 322
10 s 40, 1995 1st sp.s. c 18 s 114, 1983 1st ex.s. c 67 s 39, & 1980 c 177
11 s 77;

12 (45) RCW 74.46.780 (Appeals or exception procedure) and 1998 c 322
13 s 41, 1995 1st sp.s. c 18 s 115, 1989 c 175 s 159, 1983 1st ex.s. c 67
14 s 40, & 1980 c 177 s 78;

15 (46) RCW 74.46.790 (Denial, suspension, or revocation of license or
16 provisional license--Penalties) and 1980 c 177 s 79;

17 (47) RCW 74.46.820 (Public disclosure) and 2005 c 274 s 356, 1998
18 c 322 s 43, 1985 c 361 s 14, 1983 1st ex.s. c 67 s 41, & 1980 c 177 s
19 82;

20 (48) RCW 74.46.900 (Severability--1980 c 177) and 1980 c 177 s 93;

21 (49) RCW 74.46.901 (Effective dates--1983 1st ex.s. c 67; 1980 c
22 177) and 1983 1st ex.s. c 67 s 49, 1981 1st ex.s. c 2 s 10, & 1980 c
23 177 s 94;

24 (50) RCW 74.46.902 (Section captions--1980 c 177) and 1980 c 177 s
25 89;

26 (51) RCW 74.46.905 (Severability--1983 1st ex.s. c 67) and 1983 1st
27 ex.s. c 67 s 43; and

28 (52) RCW 74.46.906 (Effective date--1998 c 322 §§ 1-37, 40-49, and
29 52-54) and 1998 c 322 s 55.

30 NEW SECTION. **Sec. 22.** The following acts or parts of acts are
31 each repealed, effective July 1, 2011: RCW 74.46.433 (Variable return
32 component rate allocation) and 2010 1st sp.s. c ... (SSB 6872) s 4,
33 2006 c 258 s 3, 2001 1st sp.s. c 8 s 6, & 1999 c 353 s 9.

34 NEW SECTION. **Sec. 23.** This act is necessary for the immediate
35 preservation of the public peace, health, or safety, or support of the

1 state government and its existing public institutions, and takes effect
2 July 1, 2010.

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