CERTIFICATION OF ENROLLMENT

ENGROSSED SUBSTITUTE SENATE BILL 6872

Chapter 34, Laws of 2010

(partial veto)

61st Legislature
2010 1st Special Session

MEDICAID NURSING FACILITY PAYMENTS

EFFECTIVE DATE: 07/01/10 - Except section 22, which becomes effective 07/01/11.

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

BRAD OWEN

President of the Senate

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

FRANK CHOPP

Speaker of the House of Representatives

Approved May 4, 2010, 12:09 p.m., with the exception of Section 6 which is vetoed.

CHRISTINE GREGOIRE

Governor of the State of Washington

CERTIFICATE

I, Thomas Hoemann, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **ENGROSSED SUBSTITUTE SENATE BILL 6872** as passed by the Senate and the House of Representatives on the dates hereon set forth.

THOMAS HOEMANN

Secretary

FILED

May 5, 2010

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

((~~(57)~~)) (45) "Small nonessential community providers" means nonessential community providers with sixty or fewer licensed beds, regardless of how many beds are set up or in use.

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

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

((~~(59)~~)) (48) "Title XIX" or "medicaid" means the 1965 amendments to the social security act, P.L. 89-07, as amended and the medicaid program administered by the department.

((~~(60)~~)) (49) "Urban county" means a county which is located in a metropolitan statistical area as determined and defined by the United States office of management and budget or other appropriate agency or office of the federal government.

((~~(61) "Vital local provider" means a facility that meets the following qualifications:~~

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

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

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

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

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

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

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

allowance for essential community providers shall be based upon a minimum facility occupancy of eighty-five percent of licensed beds, regardless of how many beds are set up or in use. Component rate allocations in operations, property, and financing allowance for small nonessential community providers shall be based upon a minimum facility occupancy of ninety percent of licensed beds, regardless of how many beds are set up or in use. Component rate allocations in operations, property, and financing allowance for large nonessential community providers shall be based upon a minimum facility occupancy of ninety-two percent of licensed beds, regardless of how many beds are set up or in use. For all facilities, ((~~effective July 1, 2006,~~)) the component rate allocation in direct care shall be based upon actual facility occupancy. The median cost limits used to set component rate allocations shall be based on the applicable minimum occupancy percentage. In determining each facility's therapy care component rate allocation under RCW 74.46.511, the department shall apply the applicable minimum facility occupancy adjustment before creating the array of facilities' adjusted therapy costs per adjusted resident day. In determining each facility's support services component rate allocation under RCW 74.46.515(3), the department shall apply the applicable minimum facility occupancy adjustment before creating the array of facilities' adjusted support services costs per adjusted resident day. In determining each facility's operations component rate allocation under RCW 74.46.521(3), the department shall apply the minimum facility occupancy adjustment before creating the array of facilities' adjusted general operations costs per adjusted resident day.

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

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

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

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

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

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

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

~~(e)~~)) Direct care component rate allocations established in accordance with this chapter shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. The economic trends and conditions factor or factors defined in the biennial appropriations act shall not be compounded with the economic trends and conditions factor or factors defined in any other biennial appropriations acts before applying it to the direct care component rate allocation established in accordance with this chapter. When no economic trends and conditions factor or factors for either fiscal year are defined in a biennial appropriations act, no economic trends and conditions factor or factors defined in any earlier biennial appropriations act shall be applied solely or compounded to the direct care component rate allocation established in accordance with this chapter.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Sec. 6 was vetoed. See message at end of chapter.*

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(a) Exception profiling; and~~

~~(b) Establishing rates.~~

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

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

(1) The department shall:

(a) Employ the resource utilization group III case mix classification methodology. The department shall use the forty-four group index maximizing model for the resource utilization group III grouper version 5.10, but the department may revise or update the classification methodology to reflect advances or refinements in resident assessment or classification, subject to federal requirements; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) The therapy care component rate allocation corresponds to the provision of medicaid one-on-one therapy provided by a qualified therapist as defined in this chapter, including therapy supplies and therapy consultation, for one day for one medicaid resident of a nursing facility. ((~~The therapy care component rate allocation for October 1, 1998, through June 30, 2001, shall be based on adjusted therapy costs and days from calendar year 1996. The therapy component rate allocation for July 1, 2001, through June 30, 2007, shall be based on adjusted therapy costs and days from calendar year 1999. Effective July 1, 2007,~~)) T<u></u>he therapy care component rate allocation shall be based on adjusted therapy costs and days as described in RCW 74.46.431(5). The therapy care component rate shall be adjusted for economic trends and conditions as specified in RCW 74.46.431(5), and shall be determined in accordance with this section. In determining each facility's therapy care component rate allocation, the department shall apply the applicable minimum facility occupancy adjustment before creating the array of facilities' adjusted therapy care costs per adjusted resident day.

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

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

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

(c) Therapy consulting expenses for all residents.

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

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

(a) Those facilities located within urban counties; and

(b) Those located within nonurban counties.

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) ((~~Beginning October 1, 1998,~~)) T<u></u>he department shall determine each medicaid nursing facility's support services component rate allocation using cost report data specified by RCW 74.46.431(6).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(22) RCW 74.46.330 (Depreciable assets) and 1980 c 177 s 33;

(23) RCW 74.46.340 (Land, improvements--Depreciation) and 1980 c 177 s 34;

(24) RCW 74.46.350 (Methods of depreciation) and 1999 c 353 s 13 & 1980 c 177 s 35;

(25) RCW 74.46.360 (Cost basis of land and depreciation base of depreciable assets) and 1999 c 353 s 2, 1997 c 277 s 1, 1991 sp.s. c 8 s 18, & 1989 c 372 s 14;

(26) RCW 74.46.370 (Lives of assets) and 1999 c 353 s 14, 1997 c 277 s 2, & 1980 c 177 s 37;

(27) RCW 74.46.380 (Depreciable assets) and 1993 sp.s. c 13 s 5, 1991 sp.s. c 8 s 12, & 1980 c 177 s 38;

(28) RCW 74.46.390 (Gains and losses upon replacement of depreciable assets) and 1980 c 177 s 39;

(29) RCW 74.46.410 (Unallowable costs) and 2007 c 508 s 1, 2001 1st sp.s. c 8 s 3, 1998 c 322 s 17, 1995 1st sp.s. c 18 s 97, 1993 sp.s. c 13 s 6, 1991 sp.s. c 8 s 15, 1989 c 372 s 2, 1986 c 175 s 3, 1983 1st ex.s. c 67 s 17, & 1980 c 177 s 41;

(30) RCW 74.46.445 (Contractors--Rate adjustments) and 1999 c 353 s 15;

(31) RCW 74.46.533 (Combined and estimated rebased rates--Determination--Hold harmless provision) and 2007 c 508 s 6;

(32) RCW 74.46.600 (Billing period) and 1980 c 177 s 60;

(33) RCW 74.46.610 (Billing procedure--Rules) and 1998 c 322 s 32, 1983 1st ex.s. c 67 s 33, & 1980 c 177 s 61;

(34) RCW 74.46.620 (Payment) and 1998 c 322 s 33 & 1980 c 177 s 62;

(35) RCW 74.46.625 (Supplemental payments) and 1999 c 392 s 1;

(36) RCW 74.46.630 (Charges to patients) and 1998 c 322 s 34 & 1980 c 177 s 63;

(37) RCW 74.46.640 (Suspension of payments) and 1998 c 322 s 35, 1995 1st sp.s. c 18 s 112, 1983 1st ex.s. c 67 s 34, & 1980 c 177 s 64;

(38) RCW 74.46.650 (Termination of payments) and 1998 c 322 s 36 & 1980 c 177 s 65;

(39) RCW 74.46.660 (Conditions of participation) and 1998 c 322 s 37, 1992 c 215 s 1, 1991 sp.s. c 8 s 13, & 1980 c 177 s 66;

(40) RCW 74.46.680 (Change of ownership--Assignment of department's contract) and 1998 c 322 s 38, 1985 c 361 s 2, & 1980 c 177 s 68;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Passed by the Senate April 13, 2010.
Passed by the House April 13, 2010.
Approved by the Governor May 4, 2010, with the exception of certain items that were vetoed.
Filed in Office of Secretary of State May 5, 2010.

Note: Governor's explanation of partial veto is as follows:

"I am returning herewith, without my approval as to Section 6, Engrossed Substitute Senate Bill 6872 entitled:

"AN ACT Relating to medicaid nursing facility payments."

This bill makes several changes to the nursing facility rate statute.

Section 6 of this bill would reduce the financing allowance from 10 percent to 4 percent for assets purchased prior to May 17, 1999 and from 8.5 percent to 4 percent for assets purchased on or after May 17, 1999. These retroactive reductions in return on investments would apply to owners the state previously had urged to upgrade their facilities. Such changes could make additional needed investments unlikely.

For these reasons I have vetoed Section 6 of Engrossed Substitute Senate Bill 6872.

With the exception of Section 6, Engrossed Substitute Senate Bill 6872 is approved."