
HOUSE BILL 2359

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By Representatives Parlette, Cody, Edmonds, Rockefeller, B. Chandler, Schoesler, Kenney, Conway, McDonald and Van Luven

Read first time 01/11/2000. Referred to Committee on Health Care.

1 AN ACT Relating to the nursing facility payment system; amending
2 RCW 74.46.020, 74.46.370, 74.46.421, and 74.46.431; reenacting and
3 amending RCW 74.46.506; and repealing RCW 74.46.908.

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

5 **Sec. 1.** RCW 74.46.020 and 1999 c 353 s 1 are each amended to read
6 as follows:

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

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

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

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

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

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

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

22 (7) "Beneficial owner" means:

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

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

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

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

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

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

1 (ii) Through the conversion of an ownership interest;
2 (iii) Pursuant to the power to revoke a trust, discretionary
3 account, or similar arrangement; or

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

6 except that, any person who acquires an ownership interest or power
7 specified in (c)(i), (ii), or (iii) of this subsection with the purpose
8 or effect of changing or influencing the control of the contractor, or
9 in connection with or as a participant in any transaction having such
10 purpose or effect, immediately upon such acquisition shall be deemed to
11 be the beneficial owner of the ownership interest which may be acquired
12 through the exercise or conversion of such ownership interest or power;

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

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

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

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

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

33 ~~(8) ("Capital portion of the rate" means the sum of the property~~
34 ~~and financing allowance rate allocations, as established in part E of~~
35 ~~this chapter.~~

36 ~~(9))~~ "Capitalization" means the recording of an expenditure as an
37 asset.

1 (~~(10)~~) (9) "Case mix" means a measure of the intensity of care
2 and services needed by the residents of a nursing facility or a group
3 of residents in the facility.

4 (~~(11)~~) (10) "Case mix index" means a number representing the
5 average case mix of a nursing facility.

6 (~~(12)~~) (11) "Case mix weight" means a numeric score that
7 identifies the relative resources used by a particular group of a
8 nursing facility's residents.

9 (~~(13)~~) (12) "Contractor" means a person or entity licensed under
10 chapter 18.51 RCW to operate a medicare and medicaid certified nursing
11 facility, responsible for operational decisions, and contracting with
12 the department to provide services to medicaid recipients residing in
13 the facility.

14 (~~(14)~~) (13) "Default case" means no initial assessment has been
15 completed for a resident and transmitted to the department by the
16 cut-off date, or an assessment is otherwise past due for the resident,
17 under state and federal requirements.

18 (~~(15)~~) (14) "Department" means the department of social and
19 health services (DSHS) and its employees.

20 (~~(16)~~) (15) "Depreciation" means the systematic distribution of
21 the cost or other basis of tangible assets, less salvage, over the
22 estimated useful life of the assets.

23 (~~(17)~~) (16) "Direct care" means nursing care and related care
24 provided to nursing facility residents. Therapy care shall not be
25 considered part of direct care.

26 (~~(18)~~) (17) "Direct care supplies" means medical, pharmaceutical,
27 and other supplies required for the direct care of a nursing facility's
28 residents.

29 (~~(19)~~) (18) "Entity" means an individual, partnership,
30 corporation, limited liability company, or any other association of
31 individuals capable of entering enforceable contracts.

32 (~~(20)~~) (19) "Equity" means the net book value of all tangible and
33 intangible assets less the recorded value of all liabilities, as
34 recognized and measured in conformity with generally accepted
35 accounting principles.

36 (~~(21)~~) (20) "Facility" or "nursing facility" means a nursing home
37 licensed in accordance with chapter 18.51 RCW, excepting nursing homes
38 certified as institutions for mental diseases, or that portion of a
39 multiservice facility licensed as a nursing home, or that portion of a

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

3 ~~((22))~~ (21) "Fair market value" means the replacement cost of an
4 asset less observed physical depreciation on the date for which the
5 market value is being determined.

6 ~~((23))~~ (22) "Financial statements" means statements prepared and
7 presented in conformity with generally accepted accounting principles
8 including, but not limited to, balance sheet, statement of operations,
9 statement of changes in financial position, and related notes.

10 ~~((24))~~ (23) "Generally accepted accounting principles" means
11 accounting principles approved by the financial accounting standards
12 board (FASB).

13 ~~((25))~~ (24) "Goodwill" means the excess of the price paid for a
14 nursing facility business over the fair market value of all net
15 identifiable tangible and intangible assets acquired, as measured in
16 accordance with generally accepted accounting principles.

17 ~~((26))~~ (25) "Grouper" means a computer software product that
18 groups individual nursing facility residents into case mix
19 classification groups based on specific resident assessment data and
20 computer logic.

21 ~~((27))~~ (26) "Historical cost" means the actual cost incurred in
22 acquiring and preparing an asset for use, including feasibility
23 studies, architect's fees, and engineering studies.

24 ~~((28))~~ (27) "Imprest fund" means a fund which is regularly
25 replenished in exactly the amount expended from it.

26 ~~((29))~~ (28) "Joint facility costs" means any costs which
27 represent resources which benefit more than one facility, or one
28 facility and any other entity.

29 ~~((30))~~ (29) "Lease agreement" means a contract between two
30 parties for the possession and use of real or personal property or
31 assets for a specified period of time in exchange for specified
32 periodic payments. Elimination (due to any cause other than death or
33 divorce) or addition of any party to the contract, expiration, or
34 modification of any lease term in effect on January 1, 1980, or
35 termination of the lease by either party by any means shall constitute
36 a termination of the lease agreement. An extension or renewal of a
37 lease agreement, whether or not pursuant to a renewal provision in the
38 lease agreement, shall be considered a new lease agreement. A strictly
39 formal change in the lease agreement which modifies the method,

1 frequency, or manner in which the lease payments are made, but does not
2 increase the total lease payment obligation of the lessee, shall not be
3 considered modification of a lease term.

4 ~~((+31+))~~ (30) "Medical care program" or "medicaid program" means
5 medical assistance, including nursing care, provided under RCW
6 74.09.500 or authorized state medical care services.

7 ~~((+32+))~~ (31) "Medical care recipient," "medicaid recipient," or
8 "recipient" means an individual determined eligible by the department
9 for the services provided under chapter 74.09 RCW.

10 ~~((+33+))~~ (32) "Minimum data set" means the overall data component
11 of the resident assessment instrument, indicating the strengths, needs,
12 and preferences of an individual nursing facility resident.

13 ~~((+34+))~~ (33) "Net book value" means the historical cost of an
14 asset less accumulated depreciation.

15 ~~((+35+))~~ (34) "Net invested funds" means the net book value of
16 tangible fixed assets employed by a contractor to provide services
17 under the medical care program, including land, buildings, and
18 equipment as recognized and measured in conformity with generally
19 accepted accounting principles, plus an allowance of working capital
20 which shall be five percent of the product of the per-patient-day rate
21 multiplied by the prior calendar year reported total patient days of
22 each contractor.

23 ~~((+36+))~~ ~~"Noncapital portion of the rate" means the sum of the direct~~
24 ~~care, therapy care, operations, support services, and variable return~~
25 ~~rate allocations, as established in part E of this chapter.~~

26 ~~(+37+))~~ (35) "Operating lease" means a lease under which rental or
27 lease expenses are included in current expenses in accordance with
28 generally accepted accounting principles.

29 ~~((+38+))~~ (36) "Owner" means a sole proprietor, general or limited
30 partners, members of a limited liability company, and beneficial
31 interest holders of five percent or more of a corporation's outstanding
32 stock.

33 ~~((+39+))~~ (37) "Ownership interest" means all interests beneficially
34 owned by a person, calculated in the aggregate, regardless of the form
35 which such beneficial ownership takes.

36 ~~((+40+))~~ (38) "Patient day" or "resident day" means a calendar day
37 of care provided to a nursing facility resident, regardless of payment
38 source, which will include the day of admission and exclude the day of
39 discharge; except that, when admission and discharge occur on the same

1 day, one day of care shall be deemed to exist. A "medicaid day" or
2 "recipient day" means a calendar day of care provided to a medicaid
3 recipient determined eligible by the department for services provided
4 under chapter 74.09 RCW, subject to the same conditions regarding
5 admission and discharge applicable to a patient day or resident day of
6 care.

7 ~~((41))~~ (39) "Professionally designated real estate appraiser"
8 means an individual who is regularly engaged in the business of
9 providing real estate valuation services for a fee, and who is deemed
10 qualified by a nationally recognized real estate appraisal educational
11 organization on the basis of extensive practical appraisal experience,
12 including the writing of real estate valuation reports as well as the
13 passing of written examinations on valuation practice and theory, and
14 who by virtue of membership in such organization is required to
15 subscribe and adhere to certain standards of professional practice as
16 such organization prescribes.

17 ~~((42))~~ (40) "Qualified therapist" means:

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

19 (b) A mental retardation professional who is a therapist approved
20 by the department who has had specialized training or one year's
21 experience in treating or working with the mentally retarded or
22 developmentally disabled;

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

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

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

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

32 ~~((43))~~ (41) "Rate" or "rate allocation" means the medicaid per-
33 patient-day payment amount for medicaid patients calculated in
34 accordance with the allocation methodology set forth in part E of this
35 chapter.

36 ~~((44))~~ (42) "Real property," whether leased or owned by the
37 contractor, means the building, allowable land, land improvements, and
38 building improvements associated with a nursing facility.

1 (~~(45)~~) (43) "Rebased rate" or "cost-rebased rate" means a
2 facility-specific component rate assigned to a nursing facility for a
3 particular rate period established on desk-reviewed, adjusted costs
4 reported for that facility covering at least six months of a prior
5 calendar year designated as a year to be used for cost-rebasing payment
6 rate allocations under the provisions of this chapter.

7 (~~(46)~~) (44) "Records" means those data supporting all financial
8 statements and cost reports including, but not limited to, all general
9 and subsidiary ledgers, books of original entry, and transaction
10 documentation, however such data are maintained.

11 (~~(47)~~) (45) "Related organization" means an entity which is under
12 common ownership and/or control with, or has control of, or is
13 controlled by, the contractor.

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

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

21 (~~(48)~~) (46) "Related care" means only those services that are
22 directly related to providing direct care to nursing facility
23 residents. These services include, but are not limited to, nursing
24 direction and supervision, medical direction, medical records, pharmacy
25 services, activities, and social services.

26 (~~(49)~~) (47) "Resident assessment instrument," including federally
27 approved modifications for use in this state, means a federally
28 mandated, comprehensive nursing facility resident care planning and
29 assessment tool, consisting of the minimum data set and resident
30 assessment protocols.

31 (~~(50)~~) (48) "Resident assessment protocols" means those
32 components of the resident assessment instrument that use the minimum
33 data set to trigger or flag a resident's potential problems and risk
34 areas.

35 (~~(51)~~) (49) "Resource utilization groups" means a case mix
36 classification system that identifies relative resources needed to care
37 for an individual nursing facility resident.

1 (~~(52)~~) (50) "Restricted fund" means those funds the principal
2 and/or income of which is limited by agreement with or direction of the
3 donor to a specific purpose.

4 (~~(53)~~) (51) "Secretary" means the secretary of the department of
5 social and health services.

6 (~~(54)~~) (52) "Support services" means food, food preparation,
7 dietary, housekeeping, and laundry services provided to nursing
8 facility residents.

9 (~~(55)~~) (53) "Therapy care" means those services required by a
10 nursing facility resident's comprehensive assessment and plan of care,
11 that are provided by qualified therapists, or support personnel under
12 their supervision, including related costs as designated by the
13 department.

14 (~~(56)~~) (54) "Title XIX" or "medicaid" means the 1965 amendments
15 to the social security act, P.L. 89-07, as amended and the medicaid
16 program administered by the department.

17 **Sec. 2.** RCW 74.46.370 and 1999 c 353 s 14 are each amended to read
18 as follows:

19 (1) Except for new buildings, major remodels, and major repair
20 projects, as defined in subsection (2) of this section, the contractor
21 shall use lives which reflect the estimated actual useful life of the
22 asset and which shall be no shorter than guideline lives as established
23 by the department. Lives shall be measured from the date on which the
24 assets were first used in the medical care program or from the date of
25 the most recent arm's-length acquisition of the asset, whichever is
26 more recent. In cases where RCW 74.46.360(6)(a) does apply, the
27 shortest life that may be used for buildings is the remaining useful
28 life under the prior contract. In all cases, lives shall be extended
29 to reflect periods, if any, when assets were not used in or as a
30 facility.

31 (2) Effective July 1, 1997, for asset acquisitions and new
32 facilities, major remodels, and major repair projects that begin
33 operations on or after July 1, 1997, the department shall use the most
34 current edition of Estimated Useful Lives of Depreciable Hospital
35 Assets, or as it may be renamed, published by the American Hospital
36 Publishing, Inc., an American hospital association company, for
37 determining the useful life of new buildings, major remodels, and major
38 repair projects, however, the shortest life that may be used for new

1 buildings receiving certificate of need approval or certificate of need
2 exemptions under chapter 70.38 RCW on or after July 1, 1999, is
3 (~~forty~~) thirty years. New buildings, major remodels, and major
4 repair projects include those projects that meet or exceed the
5 expenditure minimum established by the department of health pursuant to
6 chapter 70.38 RCW.

7 (3) Building improvements, other than major remodels and major
8 repairs, shall be depreciated over the remaining useful life of the
9 building, as modified by the improvement.

10 (4) Improvements to leased property which are the responsibility of
11 the contractor under the terms of the lease shall be depreciated over
12 the useful life of the improvement.

13 (5) A contractor may change the estimate of an asset's useful life
14 to a longer life for purposes of depreciation.

15 (6) For new or replacement building construction or for major
16 renovations, either of which receives certificate of need approval or
17 certificate of need exemption under chapter 70.38 RCW on or after July
18 1, 1999, the number of years used to depreciate fixed equipment shall
19 be the same number of years as the life of the building to which it is
20 affixed.

21 **Sec. 3.** RCW 74.46.421 and 1999 c 353 s 3 are each amended to read
22 as follows:

23 (1) The purpose of part E of this chapter is to determine nursing
24 facility medicaid payment rates that, in the aggregate for all
25 participating nursing facilities, are in accordance with the biennial
26 appropriations act.

27 (2)(a) The department shall use the nursing facility medicaid
28 payment rate methodologies described in this chapter to determine
29 initial component rate allocations for each medicaid nursing facility.

30 (b) The initial component rate allocations shall be subject to
31 adjustment as provided in this section in order to assure that the
32 state-wide average payment rate to nursing facilities is less than or
33 equal to the state-wide average payment rate specified in the biennial
34 appropriations act.

35 (c) The state-wide average payment rate specified in the biennial
36 appropriations act shall be determined by applying the nursing facility
37 medicaid payment rate methodologies described in this chapter, allowing
38 a reasonable growth rate in the property component rate allocation, and

1 allowing a reasonable adjustment to the facility average case mix, as
2 needed.

3 (3) Nothing in this chapter shall be construed as creating a legal
4 right or entitlement to any payment that (a) has not been adjusted
5 under this section or (b) would cause the state-wide average payment
6 rate to exceed the state-wide average payment rate specified in the
7 biennial appropriations act.

8 (4)(a) The state-wide average payment rate (~~for the capital~~
9 ~~portion of the rate~~) for any state fiscal year under the nursing
10 facility medicaid payment system, weighted by patient days, shall not
11 exceed the annual state-wide weighted average nursing facility payment
12 rate (~~for the capital portion of the rate~~) identified for that fiscal
13 year in the biennial appropriations act.

14 (b) If the department determines that the weighted average nursing
15 facility payment rate (~~for the capital portion of the rate~~)
16 calculated in accordance with this chapter is likely to exceed the
17 weighted average nursing facility payment rate (~~for the capital~~
18 ~~portion of the rate~~) identified in the biennial appropriations act,
19 then the department shall adjust all nursing facility (~~property and~~
20 ~~financing allowance~~) payment rates proportional to the amount by which
21 the weighted average rate allocations would otherwise exceed the
22 budgeted (~~capital portion of the~~) rate amount. Any such adjustments
23 shall only be made prospectively, not retrospectively, and shall be
24 applied proportionately to each component rate allocation for each
25 facility.

26 (~~(5)(a) The state-wide average payment rate for the noncapital~~
27 ~~portion of the rate for any state fiscal year under the nursing~~
28 ~~facility payment system, weighted by patient days, shall not exceed the~~
29 ~~annual state-wide weighted average nursing facility payment rate for~~
30 ~~the noncapital portion of the rate identified for that fiscal year in~~
31 ~~the biennial appropriations act.~~

32 (~~(b) If the department determines that the weighted average nursing~~
33 ~~facility payment rate for the noncapital portion of the rate calculated~~
34 ~~in accordance with this chapter is likely to exceed the weighted~~
35 ~~average nursing facility payment rate for the noncapital portion of the~~
36 ~~rate identified in the biennial appropriations act, then the department~~
37 ~~shall adjust all nursing facility direct care, therapy care, support~~
38 ~~services, operations, and variable return payment rates proportional to~~
39 ~~the amount by which the weighted average rate allocations would~~

1 otherwise exceed the budgeted noncapital portion of the rate amount.
2 Any such adjustments shall only be made prospectively, not
3 retrospectively, and shall be applied proportionately to each direct
4 care, therapy care, support services, operations, and variable return
5 rate allocation for each facility.))

6 (c) Any rate adjustments made under (b) of this subsection that are
7 in excess of the amount necessary to comply with (a) of this subsection
8 shall be refunded to each nursing facility.

9 **Sec. 4.** RCW 74.46.431 and 1999 c 353 s 4 are each amended to read
10 as follows:

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

18 (2) All component rate allocations shall be based upon a minimum
19 facility occupancy of eighty-five percent of licensed beds, regardless
20 of how many beds are set up or in use.

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

27 (4)(a) Direct care component rate allocations shall be established
28 using adjusted cost report data covering at least six months. Adjusted
29 cost report data from 1996 will be used for October 1, 1998, through
30 June 30, 2001, direct care component rate allocations; adjusted cost
31 report data from 1999 will be used for July 1, 2001, through June 30,
32 2004, direct care component rate allocations.

33 (b) Beginning July 1, 2000, and for all subsequent July 1st
34 calendar year periods, the nonrebased direct care component rate
35 allocations, based on ((1996)) the rebase year cost report data, shall
36 be adjusted ((annually)) for economic trends and conditions by ((a
37 factor or factors defined in the biennial appropriations act)) the
38 change in the nursing home input price index, without capital costs,

1 published by the health care financing administration of the department
2 of health and human services (HCFA index). The period to be used to
3 measure the HCFA index increase or decrease shall be the calendar year
4 immediately preceding the July 1st nonrebased rate period. ((A
5 different)) An economic trends and conditions adjustment factor ((or
6 factors may be defined in the biennial appropriations act)) of two
7 percent shall be used to adjust the direct care component rate
8 allocations for facilities whose direct care component rate is set
9 equal to their adjusted June 30, 1998, rate, as provided in RCW
10 74.46.506(5)(k).

11 (c) Beginning July 1, 2001, the direct care component rate
12 allocations, based on 1999 cost report data, shall be adjusted
13 ((annually)) for economic trends and conditions by ((a factor or
14 factors defined in the biennial appropriations act)) the change in the
15 HCFA index for the calendar year that immediately precedes the July 1,
16 2001, rate period, multiplied by a factor of 2.0. ((A different)) An
17 economic trends and conditions adjustment factor ((or factors may be
18 defined in the biennial appropriations act)) of two percent shall be
19 used to adjust the direct care component rate allocations for
20 facilities whose direct care component rate is set equal to their
21 adjusted June 30, 1998, rate, as provided in RCW 74.46.506(5)(k).

22 (5)(a) Therapy care component rate allocations shall be established
23 using adjusted cost report data covering at least six months. Adjusted
24 cost report data from 1996 will be used for October 1, 1998, through
25 June 30, 2001, therapy care component rate allocations; adjusted cost
26 report data from 1999 will be used for July 1, 2001, through June 30,
27 2004, therapy care component rate allocations.

28 (b) Beginning July 1, 2000, and for all subsequent July 1st
29 calendar year periods, the nonrebased therapy care component rate
30 allocations, based on the rebase year cost report data, shall be
31 adjusted ((annually)) for economic trends and conditions by ((a factor
32 or factors defined in the biennial appropriations act)) the change in
33 the nursing home input price index, without capital costs, published by
34 the health care financing administration of the department of health
35 and human services (HCFA index). The period to be used to measure the
36 HCFA index increase or decrease shall be the calendar year immediately
37 preceding the July 1st nonrebased rate period.

38 (c) Beginning July 1, 2001, the therapy care component rate
39 allocations, based on 1999 cost report data, shall be adjusted for

1 economic trends and conditions by the change in the HCFA index for the
2 calendar year that immediately precedes the July 1, 2001, rate period,
3 multiplied by a factor of 2.0.

4 (6)(a) Support services component rate allocations shall be
5 established using adjusted cost report data covering at least six
6 months. Adjusted cost report data from 1996 shall be used for October
7 1, 1998, through June 30, 2001, support services component rate
8 allocations; adjusted cost report data from 1999 shall be used for July
9 1, 2001, through June 30, 2004, support services component rate
10 allocations.

11 (b) Beginning July 1, 2000, and for all subsequent July 1st
12 calendar year periods, the nonrebased support services component rate
13 allocations, based on the rebase year cost report data, shall be
14 adjusted ((annually)) for economic trends and conditions by ((a factor
15 or factors defined in the biennial appropriations act)) the change in
16 the nursing home input price index, without capital costs, published by
17 the health care financing administration of the department of health
18 and human services (HCFA index). The period to be used to measure the
19 HCFA index increase or decrease shall be the calendar year immediately
20 preceding the July 1st nonrebased rate period.

21 (c) Beginning July 1, 2001, support services component rate
22 allocations, based on 1999 cost report data, shall be adjusted for
23 economic trends and conditions by the change in the HCFA index for the
24 calendar year that immediately precedes the July 1, 2001, rate period,
25 multiplied by a factor of 2.0.

26 (7)(a) Operations component rate allocations shall be established
27 using adjusted cost report data covering at least six months. Adjusted
28 cost report data from 1996 shall be used for October 1, 1998, through
29 June 30, 2001, operations component rate allocations; adjusted cost
30 report data from 1999 shall be used for July 1, 2001, through June 30,
31 2004, operations component rate allocations.

32 (b) Beginning July 1, 2000, and for all subsequent July 1st
33 calendar year periods, the nonrebased operations component rate
34 allocations, based on the rebase year cost report data, shall be
35 adjusted ((annually)) for economic trends and conditions by ((a factor
36 or factors defined in the biennial appropriations act)) the change in
37 the nursing home input price index, without capital costs, published by
38 the health care financing administration of the department of health
39 and human services (HCFA index). The period to be used to measure the

1 HCFA index increase or decrease shall be the calendar year immediately
2 preceding the July 1st nonrebased rate period.

3 (c) Beginning July 1, 2001, the operations component rate
4 allocations, based on 1999 cost report data, shall be adjusted for
5 economic trends and conditions by the change in the HCFA index for the
6 calendar year that immediately precedes the July 1, 2001, rate period,
7 multiplied by a factor of 2.0.

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

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

18 ~~((10))~~ (9) Medicaid contractors shall pay to all facility staff
19 a minimum wage of the greater of five dollars and fifteen cents per
20 hour or the federal minimum wage.

21 ~~((11))~~ (10) The department shall establish in rule procedures,
22 principles, and conditions for determining component rate allocations
23 for facilities in circumstances not directly addressed by this chapter,
24 including but not limited to: The need to prorate inflation for
25 partial-period cost report data, newly constructed facilities, existing
26 facilities entering the medicaid program for the first time or after a
27 period of absence from the program, existing facilities with expanded
28 new bed capacity, existing medicaid facilities following a change of
29 ownership of the nursing facility business, facilities banking beds or
30 converting beds back into service, facilities having less than six
31 months of either resident assessment, cost report data, or both, under
32 the current contractor prior to rate setting, and other circumstances.

33 ~~((12))~~ (11) The department shall establish in rule procedures,
34 principles, and conditions, including necessary threshold costs, for
35 adjusting rates to reflect capital improvements or new requirements
36 imposed by the department or the federal government. Any such rate
37 adjustments are subject to the provisions of RCW 74.46.421.

1 **Sec. 5.** RCW 74.46.506 and 1999 c 353 s 5 and 1999 c 181 s 1 are
2 each reenacted and amended to read as follows:

3 (1) The direct care component rate allocation corresponds to the
4 provision of nursing care for one resident of a nursing facility for
5 one day, including direct care supplies. Therapy services and
6 supplies, which correspond to the therapy care component rate, shall be
7 excluded. The direct care component rate includes elements of case mix
8 determined consistent with the principles of this section and other
9 applicable provisions of this chapter.

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

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

27 (4) Cost report data used in setting direct care component rate
28 allocations shall be 1996 and 1999, for rate periods as specified in
29 RCW 74.46.431(4)(a).

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

36 (a) Reduce total direct care costs reported by each nursing
37 facility for the applicable cost report period specified in RCW
38 74.46.431(4)(a) to reflect any department adjustments, and to eliminate

1 reported resident therapy costs and adjustments, in order to derive the
2 facility's total allowable direct care cost;

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

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

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

16 (e) Divide nursing facilities into two peer groups: Those located
17 in metropolitan statistical areas as determined and defined by the
18 United States office of management and budget or other appropriate
19 agency or office of the federal government, and those not located in a
20 metropolitan statistical area;

21 (f) Array separately the allowable direct care cost per case mix
22 unit for all metropolitan statistical area and for all nonmetropolitan
23 statistical area facilities, and determine the median allowable direct
24 care cost per case mix unit for each peer group;

25 (g) Except as provided in (k) of this subsection, from October 1,
26 1998, through June 30, 2000, determine each facility's quarterly direct
27 care component rate as follows:

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

36 (ii) Any facility whose allowable cost per case mix unit is greater
37 than one hundred fifteen percent of the peer group median established
38 under (f) of this subsection shall be assigned a cost per case mix unit
39 equal to one hundred fifteen percent of the peer group median, and

1 shall have a direct care component rate allocation equal to the
2 facility's assigned cost per case mix unit multiplied by that
3 facility's medicaid average case mix index from the applicable quarter
4 specified in RCW 74.46.501(7)(c);

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

11 (h) Except as provided in (k) of this subsection, from July 1,
12 2000, through June 30, 2002, determine each facility's quarterly direct
13 care component rate as follows:

14 (i) Any facility whose allowable cost per case mix unit is less
15 than ninety percent of the facility's peer group median established
16 under (f) of this subsection shall be assigned a cost per case mix unit
17 equal to ninety percent of the facility's peer group median, and shall
18 have a direct care component rate allocation equal to the facility's
19 assigned cost per case mix unit multiplied by that facility's medicaid
20 average case mix index from the applicable quarter specified in RCW
21 74.46.501(7)(c);

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

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

36 (i) From July 1, 2002, through June 30, 2004, determine each
37 facility's quarterly direct care component rate as follows:

38 (i) Any facility whose allowable cost per case mix unit is less
39 than ninety-five percent of the facility's peer group median

1 established under (f) of this subsection shall be assigned a cost per
2 case mix unit equal to ninety-five percent of the facility's peer group
3 median, and shall have a direct care component rate allocation equal to
4 the facility's assigned cost per case mix unit multiplied by that
5 facility's medicaid average case mix index from the applicable quarter
6 specified in RCW 74.46.501(7)(c);

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

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

21 (j) Beginning July 1, 2004, determine each facility's quarterly
22 direct care component rate by multiplying the facility's peer group
23 median allowable direct care cost per case mix unit by that facility's
24 medicaid average case mix index from the applicable quarter as
25 specified in RCW 74.46.501(7)(c).

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

33 (ii) Between July 1, 2000, and June 30, 2002, the department shall
34 compare each facility's direct care component rate allocation
35 calculated under (h) of this subsection with the facility's direct care
36 component rate in effect on June 30, 2000, adjusted for economic trends
37 and conditions as provided in RCW 74.46.431. A facility shall receive
38 the higher of the two rates.

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

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

11 NEW SECTION. **Sec. 6.** RCW 74.46.908 (Repealer) and 1999 c 353 s 17
12 are each repealed.

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