FIFTEENTH DAY

MORNING SESSION

Senate Chamber, Olympia, Tuesday, May 10, 2011

The Senate was called to order at 10:00 a.m. by President Owen. The Secretary called the roll and announced to the President that all Senators were present with the exception of Senators Benton, Sheldon, Shin and Swecker.

The Sergeant at Arms Color Guard consisting of Senate staff Peg Amandes and Kevin Black, presented the Colors. Senator Haugen offered the prayer.

MOTION

On motion of Senator Eide, the reading of the Journal of the previous day was dispensed with and it was approved.

MOTION

On motion of Senator Eide, the Senate advanced to the fourth order of business.

MESSAGE FROM THE HOUSE

May 9, 2011

MR. PRESIDENT:
The House has passed:
ENGROSSED SECOND SUBSTITUTE HOUSE BILL 1795,
ENGROSSED HOUSE BILL 2069.
and the same are herewith transmitted.

BARBARA BAKER, Chief Clerk

MESSAGE FROM THE HOUSE

May 9, 2011

MR. PRESIDENT:
The House has passed:
HOUSE BILL 1131,
SECOND SUBSTITUTE HOUSE BILL 1132.
and the same are herewith transmitted.

BARBARA BAKER, Chief Clerk

MOTION

On motion of Senator Eide, the Senate advanced to the fifth order of business.

INTRODUCTION AND FIRST READING

SB 5955 by Senators Kohl-Welles, Delvin, Keiser, Pflug, Regala, Brown, Prentice, Murray, Tom and Kline

AN ACT Relating to medical use of cannabis; amending RCW 69.51A.010, 69.51A.030, 69.51A.040, 69.51A.---, 69.51A.---, 69.51A.050, 69.51A.---, 69.51A.---, 82.08.0281, and 82.12.0275; adding new sections to chapter 69.51A RCW; adding a new section to chapter 42.56 RCW; and repealing RCW 69.51A.---.

Referred to Committee on Ways & Means.

MOTION

On motion of Senator Eide, the measure listed on the Introduction and First Reading report was referred to the committee as designated.

MOTION

At 10:08 a.m., on motion of Senator Eide, the Senate was declared to be at ease subject to the call of the President.

AFTERNOON SESSION

The Senate was called to order at 12:22 p.m. by President Owen.

SIGNED BY THE PRESIDENT

The President signed:
HOUSE CONCURRENT RESOLUTION 4405.

MOTION

On motion of Senator Ericksen, Senators Benton and Swecker were excused.

SUPPLEMENTAL INTRODUCTION AND FIRST READING OF HOUSE BILLS

HB 1131 by Representative Haigh

AN ACT Relating to student achievement fund allocations; reenacting and amending RCW 28A.505.220; providing an effective date; and declaring an emergency.

Referred to Committee on Ways & Means.

2SHB 1132 by House Committee on Ways & Means (originally sponsored by Representative Haigh)

AN ACT Relating to reducing compensation for educational and academic employees; amending RCW 28A.400.205, 28B.50.465, 28B.50.468, 28A.405.415, and 28A.415.020; reenacting and amending RCW 28A.415.023; providing an effective date; and declaring an emergency.

Referred to Committee on Ways & Means.

E2SHB 1795 by House Committee on Ways & Means (originally sponsored by Representatives Carlyle, Seaquist, Haler, Reykdal, Rolfes, Probst, Morris, Sells, Pedersen, Jacks, Hudgins, Maxwell and Frockt)

AN ACT Relating to the higher education opportunity act; amending RCW 28B.15.031, 28B.15.067, 28B.15.0681, 28B.15.068, 28B.76.270, 28B.92.060, 28A.600.310, 39.29.011, 43.19.1906, 43.88.160, 43.03.220, 43.03.230, 43.03.240, 43.03.250, and 43.03.265; amending 2010 c 3 ss 602, 603, and 604 (uncodified); amending 2010 1st sp.s. c 37 s 901 (uncodified); amending 2010 c 1 s 8 (uncodified);

adding new sections to chapter 28B.15 RCW; adding a new section to chapter 28B.10 RCW; adding a new section to chapter 28B.50 RCW; adding a new section to chapter 28B.76 RCW; adding a new section to chapter 44.28 RCW; creating new sections; repealing RCW 28B.10.920, 28B.10.921, and 28B.10.922; providing expiration dates; and declaring an emergency.

EHB 2069 by Representative Cody

AN ACT Relating to increasing the sum available to the state from the hospital safety net assessment fund by reducing hospital payments; amending RCW 74.60.020 and 74.60.090; providing an effective date; providing an expiration date; and declaring an emergency.

Referred to Committee on Ways & Means.

MOTION

On motion of Senator Eide, all measures listed on the Introduction and First Reading report were referred to the committees as designated with the exception of Engrossed Second Substitute House Bill No. 1795 which without objection, was placed on the second reading calendar under suspension of the rules.

MOTION

On motion of Senator Eide, the Senate reverted to the fourth order of business.

MESSAGE FROM THE HOUSE

May 9, 2011

MR. PRESIDENT:
The House passed ENGROSSED SECOND SUBSTITUTE SENATE BILL NO. 5596 with the following amendment(s): 5596-S2.E AMH CODY H2780.3

Strike everything after the enacting clause and insert the following:

"NEW SECTION. **Sec. 1.** The legislature finds that mounting budget pressures combined with growth in enrollment and constraints in the medicaid program have forced open discussion throughout the country and in our state concerning complete withdrawal from the medicaid program. The legislature recognizes that a better and more sustainable way forward would involve new state flexibility for managing its medicaid program built on the success of the basic health plan and Washington's transitional bridge waiver, where elements of consumer participation and choice, benefit design flexibility, and payment flexibility have helped keep costs low. The legislature further finds that either a centers for medicare and medicaid services' innovation center project or a section 1115 demonstration project, or both, with capped eligibility group per capita payments would allow the state to operate as a laboratory of innovation for bending the cost curve, preserving the safety net, and improving the management of care for low-income populations.

NEW SECTION. **Sec. 2.** A new section is added to chapter 74.09 RCW to read as follows:

(1) By October 1, 2011, the department shall submit a request to the centers for medicare and medicaid services' innovation center and, if necessary, a request under section 1115 of the social security act, to implement a medicaid and state children's health insurance program demonstration project. The demonstration project shall be designed to achieve the broadest federal financial participation and, to the extent permitted under federal law, shall authorize:

(a) Establishment of base-year, eligibility group per capita payments, with maximum flexibility provided to the state for managing the health care trend and provisions for shared savings if per capita expenditures are below the negotiated rates. The capped eligibility group per capita payments shall: (i) Be based on targeted per capita costs for the full duration of the demonstration period; (ii) include due consideration and flexibility for unforeseen events, changes in the delivery of health care, and changes in federal or state law; and (iii) take into account the effect of the federal patient protection and affordable care act on federal resources devoted to medicaid and state children's health insurance programs. Federal payments for each eligibility group shall be based on the product of the negotiated per capita payments for the eligibility group multiplied by the actual caseload for the eligibility group;

(b) Coverage of benefits determined to be essential health benefits under section 1302(b) of the federal patient protection and affordable care act, 42 U.S.C. 18022(b), with coverage of benefits in addition to the essential health benefits as appropriate for distinct categories of enrollees such as children, pregnant women, individuals with disabilities, and elderly adults.

(c) Limited, reasonable, and enforceable cost sharing and premiums to encourage informed consumer behavior and appropriate utilization of health services, while ensuring that access to evidence-based, preventative and primary care is not hindered;

(d) Streamlined eligibility determinations;

(e) Innovative reimbursement methods such as bundled, global, and risk-bearing payment arrangements, that promote effective purchasing, efficient use of health services, and support health homes, accountable care organizations, and other innovations intended to contain costs, improve health, and incent smart consumer decision making;

(f) Clients to voluntarily enroll in the insurance exchange, and broadened enrollment in employer-sponsored insurance when available and deemed cost-effective for the state, with authority to require clients to remain enrolled in their chosen plan for the calendar year;

(g) An expedited process of forty-five days or less in which the centers for medicare and medicaid services must respond to any state request for changes to the demonstration project once it is implemented to ensure that the state has the necessary flexibility to manage within its eligibility group per capita payment caps; and

(h) The development of an alternative payment methodology for federally qualified health centers and rural health clinics that enables capitated or global payment of enhanced payments.

(2) The department shall provide status reports to the joint legislative select committee on health reform implementation as requested by the committee.

(3) The department shall provide multiple opportunities for stakeholders and the general public to review and comment on the request as it developed.

(4) The department shall identify changes to state law necessary to ensure successful and timely implementation of the demonstration project."

Correct the title.

and the same are herewith transmitted.

BARBARA BAKER, Chief Clerk

MOTION

Senator Parlette moved that the Senate concur in the House amendment(s) to Engrossed Second Substitute Senate Bill No. 5596.

Senators Parlette and Keiser spoke in favor of the motion.

The President declared the question before the Senate to be the motion by Senator Parlette that the Senate concur in the House amendment(s) to Engrossed Second Substitute Senate Bill No. 5596.

The motion by Senator Parlette carried and the Senate concurred in the House amendment(s) to Engrossed Second Substitute Senate Bill No. 5596 by voice vote.

The President declared the question before the Senate to be the final passage of Engrossed Second Substitute Senate Bill No. 5596, as amended by the House.

ROLL CALL

The Secretary called the roll on the final passage of Engrossed Second Substitute Senate Bill No. 5596, as amended by the House, and the bill passed the Senate by the following vote: Yeas, 45; Nays, 0; Absent, 2; Excused, 2.

Voting yea: Senators Baumgartner, Baxter, Becker, Brown, Carrell, Chase, Conway, Delvin, Eide, Ericksen, Fain, Fraser, Hargrove, Harper, Hatfield, Haugen, Hewitt, Hill, Hobbs, Holmquist Newbry, Honeyford, Kastama, Keiser, Kilmer, King, Kline, Kohl-Welles, Litzow, McAuliffe, Morton, Murray, Nelson, Parlette, Pflug, Prentice, Pridemore, Ranker, Regala, Roach, Rockefeller, Schoesler, Stevens, Tom, White and Zarelli

Absent: Senators Sheldon and Shin

Excused: Senators Benton and Swecker

ENGROSSED SECOND SUBSTITUTE SENATE BILL NO. 5596, as amended by the House, having received the constitutional majority, was declared passed. There being no objection, the title of the bill was ordered to stand as the title of the act.

MOTION

On motion of Senator White, Senators Sheldon and Shin were excused.

MESSAGE FROM THE HOUSE

May 9, 2011

MR. PRESIDENT:
The House passed ENGROSSED SUBSTITUTE SENATE BILL NO. 5927 with the following amendment(s): 5927-S.E AMH WAYS H2773.1

Strike everything after the enacting clause and insert the following:

"NEW SECTION. **Sec. 1.** (1) The legislature finds that:

(a) There is an increasing level of dispute and uncertainty regarding the amount of payment nonparticipating providers may receive for health care services provided to enrollees of state purchased health care programs designed to serve low-income individuals and families, such as basic health and the medicaid managed care programs;

(b) The dispute has resulted in litigation, including a recent Washington superior court ruling that determined nonparticipating providers were entitled to receive billed charges from a managed health care system for services provided to medicaid and basic health plan enrollees. The decision would allow a nonparticipating provider to demand and receive payment in an amount exceeding the payment managed health care system network providers receive for the same services. Similar provider lawsuits have now been filed in other jurisdictions in the state;

(c) In the biennial operating budget, the legislature has previously indicated its intent that payment to nonparticipating providers for services provided to medicaid managed care enrollees should be limited to amounts paid to medicaid fee-for-service providers. The duration of these provisions is limited to the period during which the operating budget is in effect. A more permanent resolution of these issues is needed; and

(d) Continued failure to resolve this dispute will have adverse impacts on state purchased health care programs serving low-income enrollees, including: (i) Diminished ability for the state to negotiate cost-effective contracts with managed health care systems; (ii) a potential for significant reduction in the willingness of providers to participate in managed health care system provider networks; (iii) a reduction in providers participating in the managed health care systems; and (iv) increased exposure for program enrollees to balance billing practices by nonparticipating providers. Ultimately, fewer eligible people will get the care they need as state purchased health care programs will operate with less efficiency and reduced access to cost-effective and quality health care coverage for program enrollees.

(2) It is the intent of the legislature to create a legislative solution that reduces the cost borne by the state to provide public health care coverage to low-income enrollees in managed health care systems, protects enrollees and state purchased health care programs from balance billing by nonparticipating providers, provides appropriate payment to health care providers for services provided to enrollees of state purchased health care programs, and limits the risk for managed health care systems that contract with the state programs.

Sec. 2. RCW 74.09.522 and 1997 c 59 s 15 and 1997 c 34 s 1 are each reenacted and amended to read as follows:

(1) For the purposes of this section((~~,~~)):

(a) "Managed health care system" means any health care organization, including health care providers, insurers, health care service contractors, health maintenance organizations, health insuring organizations, or any combination thereof, that provides directly or by contract health care services covered under ((~~RCW 74.09.520~~)) this chapter and rendered by licensed providers, on a prepaid capitated basis and that meets the requirements of section 1903(m)(1)(A) of Title XIX of the federal social security act or federal demonstration waivers granted under section 1115(a) of Title XI of the federal social security act;

(b) "Nonparticipating provider" means a person, health care provider, practitioner, facility, or entity, acting within their scope of practice, that does not have a written contract to participate in a managed health care system's provider network, but provides health care services to enrollees of programs authorized under this chapter whose health care services are provided by the managed health care system.

(2) The department of social and health services shall enter into agreements with managed health care systems to provide health care services to recipients of temporary assistance for needy families under the following conditions:

(a) Agreements shall be made for at least thirty thousand recipients statewide;

(b) Agreements in at least one county shall include enrollment of all recipients of temporary assistance for needy families;

(c) To the extent that this provision is consistent with section 1903(m) of Title XIX of the federal social security act or federal demonstration waivers granted under section 1115(a) of Title XI of the federal social security act, recipients shall have a choice of systems in which to enroll and shall have the right to terminate their enrollment in a system: PROVIDED, That the department may limit recipient termination of enrollment without cause to the first month of a period of enrollment, which period shall not exceed twelve months: AND PROVIDED FURTHER, That the department shall not restrict a recipient's right to terminate

enrollment in a system for good cause as established by the department by rule;

(d) To the extent that this provision is consistent with section 1903(m) of Title XIX of the federal social security act, participating managed health care systems shall not enroll a disproportionate number of medical assistance recipients within the total numbers of persons served by the managed health care systems, except as authorized by the department under federal demonstration waivers granted under section 1115(a) of Title XI of the federal social security act;

(e) In negotiating with managed health care systems the department shall adopt a uniform procedure to negotiate and enter into contractual arrangements, including standards regarding the quality of services to be provided; and financial integrity of the responding system;

(f) The department shall seek waivers from federal requirements as necessary to implement this chapter;

(g) The department shall, wherever possible, enter into prepaid capitation contracts that include inpatient care. However, if this is not possible or feasible, the department may enter into prepaid capitation contracts that do not include inpatient care;

(h) The department shall define those circumstances under which a managed health care system is responsible for out-of-plan services and assure that recipients shall not be charged for such services; and

(i) Nothing in this section prevents the department from entering into similar agreements for other groups of people eligible to receive services under this chapter.

(3) The department shall ensure that publicly supported community health centers and providers in rural areas, who show serious intent and apparent capability to participate as managed health care systems are seriously considered as contractors. The department shall coordinate its managed care activities with activities under chapter 70.47 RCW.

(4) The department shall work jointly with the state of Oregon and other states in this geographical region in order to develop recommendations to be presented to the appropriate federal agencies and the United States congress for improving health care of the poor, while controlling related costs.

(5) The legislature finds that competition in the managed health care marketplace is enhanced, in the long term, by the existence of a large number of managed health care system options for medicaid clients. In a managed care delivery system, whose goal is to focus on prevention, primary care, and improved enrollee health status, continuity in care relationships is of substantial importance, and disruption to clients and health care providers should be minimized. To help ensure these goals are met, the following principles shall guide the department in its healthy options managed health care purchasing efforts:

(a) All managed health care systems should have an opportunity to contract with the department to the extent that minimum contracting requirements defined by the department are met, at payment rates that enable the department to operate as far below appropriated spending levels as possible, consistent with the principles established in this section.

(b) Managed health care systems should compete for the award of contracts and assignment of medicaid beneficiaries who do not voluntarily select a contracting system, based upon:

(i) Demonstrated commitment to or experience in serving low-income populations;

(ii) Quality of services provided to enrollees;

(iii) Accessibility, including appropriate utilization, of services offered to enrollees;

(iv) Demonstrated capability to perform contracted services, including ability to supply an adequate provider network;

(v) Payment rates; and

(vi) The ability to meet other specifically defined contract requirements established by the department, including consideration of past and current performance and participation in other state or federal health programs as a contractor.

(c) Consideration should be given to using multiple year contracting periods.

(d) Quality, accessibility, and demonstrated commitment to serving low-income populations shall be given significant weight in the contracting, evaluation, and assignment process.

(e) All contractors that are regulated health carriers must meet state minimum net worth requirements as defined in applicable state laws. The department shall adopt rules establishing the minimum net worth requirements for contractors that are not regulated health carriers. This subsection does not limit the authority of the department to take action under a contract upon finding that a contractor's financial status seriously jeopardizes the contractor's ability to meet its contract obligations.

(f) Procedures for resolution of disputes between the department and contract bidders or the department and contracting carriers related to the award of, or failure to award, a managed care contract must be clearly set out in the procurement document. In designing such procedures, the department shall give strong consideration to the negotiation and dispute resolution processes used by the Washington state health care authority in its managed health care contracting activities.

(6) The department may apply the principles set forth in subsection (5) of this section to its managed health care purchasing efforts on behalf of clients receiving supplemental security income benefits to the extent appropriate.

(7) A managed health care system shall pay a nonparticipating provider that provides a service covered under this chapter to the system's enrollee no more than the lowest amount paid for that service under the managed health care system's contracts with similar providers in the state.

(8) For services covered under this chapter to medical assistance or medical care services enrollees and provided on or after the effective date of this section, nonparticipating providers must accept as payment in full the amount paid by the managed health care system under subsection (7) of this section in addition to any deductible, coinsurance, or copayment that is due from the enrollee for the service provided. An enrollee is not liable to any nonparticipating provider for covered services, except for amounts due for any deductible, coinsurance, or copayment under the terms and conditions set forth in the managed health care system contract to provide services under this section.

(9) Pursuant to federal managed care access standards, 42 C.F.R. Sec. 438, managed health care systems must maintain a network of appropriate providers that is supported by written agreements sufficient to provide adequate access to all services covered under the contract with the department, including hospital-based physician services. The department will monitor and periodically report on the proportion of services provided by contracted providers and nonparticipating providers, by county, for each managed health care system to ensure that managed health care systems are meeting network adequacy requirements. No later than January 1st of each year, the department will review and report its findings to the appropriate policy and fiscal committees of the legislature for the preceding state fiscal year.

(10) Subsections (7) through (9) of this section expire July 1, 2016.

Sec. 3. RCW 70.47.020 and 2011 c 205 s 1 are each reenacted and amended to read as follows:

As used in this chapter:

(1) "Administrator" means the Washington basic health plan administrator, who also holds the position of administrator of the Washington state health care authority.

(2) "Health coverage tax credit eligible enrollee" means individual workers and their qualified family members who lose their jobs due to the effects of international trade and are eligible for certain trade adjustment assistance benefits; or are eligible for benefits under the alternative trade adjustment assistance program; or are people who receive benefits from the pension benefit guaranty corporation and are at least fifty-five years old.

(3) "Health coverage tax credit program" means the program created by the Trade Act of 2002 (P.L. 107-210) that provides a federal tax credit that subsidizes private health insurance coverage for displaced workers certified to receive certain trade adjustment assistance benefits and for individuals receiving benefits from the pension benefit guaranty corporation.

(4) "Managed health care system" means: (a) Any health care organization, including health care providers, insurers, health care service contractors, health maintenance organizations, or any combination thereof, that provides directly or by contract basic health care services, as defined by the administrator and rendered by duly licensed providers, to a defined patient population enrolled in the plan and in the managed health care system; or (b) a self-funded or self-insured method of providing insurance coverage to subsidized enrollees provided under RCW 41.05.140 and subject to the limitations under RCW 70.47.100((~~(7)~~)) (9).

(5) "Nonparticipating provider" means a person, health care provider, practitioner, facility, or entity, acting within their authorized scope of practice or licensure, that does not have a written contract to participate in a managed health care system's provider network, but provides services to plan enrollees who receive coverage through the managed health care system.

(6) "Nonsubsidized enrollee" means an individual, or an individual plus the individual's spouse or dependent children: (a) Who is not eligible for medicare; (b) who is not confined or residing in a government-operated institution, unless he or she meets eligibility criteria adopted by the administrator; (c) who is accepted for enrollment by the administrator as provided in RCW 48.43.018, either because the potential enrollee cannot be required to complete the standard health questionnaire under RCW 48.43.018, or, based upon the results of the standard health questionnaire, the potential enrollee would not qualify for coverage under the Washington state health insurance pool; (d) who resides in an area of the state served by a managed health care system participating in the plan; (e) who chooses to obtain basic health care coverage from a particular managed health care system; and (f) who pays or on whose behalf is paid the full costs for participation in the plan, without any subsidy from the plan.

((~~(6)~~)) (7) "Premium" means a periodic payment, which an individual, their employer or another financial sponsor makes to the plan as consideration for enrollment in the plan as a subsidized enrollee, a nonsubsidized enrollee, or a health coverage tax credit eligible enrollee.

((~~(7)~~)) (8) "Rate" means the amount, negotiated by the administrator with and paid to a participating managed health care system, that is based upon the enrollment of subsidized, nonsubsidized, and health coverage tax credit eligible enrollees in the plan and in that system.

((~~(8)~~)) (9) "Subsidy" means the difference between the amount of periodic payment the administrator makes to a managed health care system on behalf of a subsidized enrollee plus the administrative cost to the plan of providing the plan to that subsidized enrollee, and the amount determined to be the subsidized enrollee's responsibility under RCW 70.47.060(2).

((~~(9)~~)) (10) "Subsidized enrollee" means:

(a) An individual, or an individual plus the individual's spouse or dependent children:

(i) Who is not eligible for medicare;

(ii) Who is not confined or residing in a government-operated institution, unless he or she meets eligibility criteria adopted by the administrator;

(iii) Who is not a full-time student who has received a temporary visa to study in the United States;

(iv) Who resides in an area of the state served by a managed health care system participating in the plan;

(v) Until March 1, 2011, whose gross family income at the time of enrollment does not exceed two hundred percent of the federal poverty level as adjusted for family size and determined annually by the federal department of health and human services;

(vi) Who chooses to obtain basic health care coverage from a particular managed health care system in return for periodic payments to the plan;

(vii) Who is not receiving medical assistance administered by the department of social and health services; and

(viii) After February 28, 2011, who is in the basic health transition eligibles population under 1115 medicaid demonstration project number 11-W-00254/10;

(b) An individual who meets the requirements in (a)(i) through (iv), (vi), and (vii) of this subsection and who is a foster parent licensed under chapter 74.15 RCW and whose gross family income at the time of enrollment does not exceed three hundred percent of the federal poverty level as adjusted for family size and determined annually by the federal department of health and human services; and

(c) To the extent that state funds are specifically appropriated for this purpose, with a corresponding federal match, an individual, or an individual's spouse or dependent children, who meets the requirements in (a)(i) through (iv), (vi), and (vii) of this subsection and whose gross family income at the time of enrollment is more than two hundred percent, but less than two hundred fifty-one percent, of the federal poverty level as adjusted for family size and determined annually by the federal department of health and human services.

((~~(10)~~)) (11) "Washington basic health plan" or "plan" means the system of enrollment and payment for basic health care services, administered by the plan administrator through participating managed health care systems, created by this chapter.

Sec. 4. RCW 70.47.100 and 2009 c 568 s 5 are each amended to read as follows:

(1) A managed health care system participating in the plan shall do so by contract with the administrator and shall provide, directly or by contract with other health care providers, covered basic health care services to each enrollee covered by its contract with the administrator as long as payments from the administrator on behalf of the enrollee are current. A participating managed health care system may offer, without additional cost, health care benefits or services not included in the schedule of covered services under the plan. A participating managed health care system shall not give preference in enrollment to enrollees who accept such additional health care benefits or services. Managed health care systems participating in the plan shall not discriminate against any potential or current enrollee based upon health status, sex, race, ethnicity, or religion. The administrator may receive and act upon complaints from enrollees regarding failure to provide covered services or efforts to obtain payment, other than authorized copayments, for covered services directly from enrollees, but nothing in this chapter empowers the administrator to impose any sanctions under Title 18 RCW or any other professional or facility licensing statute.

(2) A managed health care system shall pay a nonparticipating provider that provides a service covered under this chapter to the system's enrollee no more than the lowest amount paid for that service under the managed health care system's contracts with similar providers in the state.

(3) Pursuant to federal managed care access standards, 42 C.F.R. Sec. 438, managed health care systems must maintain a network of appropriate providers that is supported by written agreements sufficient to provide adequate access to all services covered under the contract with the authority, including hospital-based physician services. The authority will monitor and periodically report on the proportion of services provided by contracted providers and nonparticipating providers, by county, for each managed health care system to ensure that managed health care systems are meeting network adequacy requirements. No later than January 1st of each year, the authority will review and report its findings to the appropriate policy and fiscal committees of the legislature for the preceding state fiscal year.

(4) The plan shall allow, at least annually, an opportunity for enrollees to transfer their enrollments among participating managed health care systems serving their respective areas. The administrator shall establish a period of at least twenty days in a given year when this opportunity is afforded enrollees, and in those areas served by more than one participating managed health care system the administrator shall endeavor to establish a uniform period for such opportunity. The plan shall allow enrollees to transfer their enrollment to another participating managed health care system at any time upon a showing of good cause for the transfer.

(((~~(3)~~))) (5) Prior to negotiating with any managed health care system, the administrator shall determine, on an actuarially sound basis, the reasonable cost of providing the schedule of basic health care services, expressed in terms of upper and lower limits, and recognizing variations in the cost of providing the services through the various systems and in different areas of the state.

(((~~(4)~~))) (6) In negotiating with managed health care systems for participation in the plan, the administrator shall adopt a uniform procedure that includes at least the following:

(a) The administrator shall issue a request for proposals, including standards regarding the quality of services to be provided; financial integrity of the responding systems; and responsiveness to the unmet health care needs of the local communities or populations that may be served;

(b) The administrator shall then review responsive proposals and may negotiate with respondents to the extent necessary to refine any proposals;

(c) The administrator may then select one or more systems to provide the covered services within a local area; and

(d) The administrator may adopt a policy that gives preference to respondents, such as nonprofit community health clinics, that have a history of providing quality health care services to low-income persons.

(((~~(5)~~))) (7) The administrator may contract with a managed health care system to provide covered basic health care services to subsidized enrollees, nonsubsidized enrollees, health coverage tax credit eligible enrollees, or any combination thereof.

(((~~(6)~~))) (8) The administrator may establish procedures and policies to further negotiate and contract with managed health care systems following completion of the request for proposal process in subsection (((~~(4)~~))) (6) of this section, upon a determination by the administrator that it is necessary to provide access, as defined in the request for proposal documents, to covered basic health care services for enrollees.

(((~~(7)~~))) (9) The administrator may implement a self-funded or self- insured method of providing insurance coverage to subsidized enrollees, as provided under RCW 41.05.140. Prior to implementing a self-funded or self-insured method, the administrator shall ensure that funding available in the basic health plan self-insurance reserve account is sufficient for the self-funded or self-insured risk assumed, or expected to be assumed, by the administrator. If implementing a self- funded or self-insured method, the administrator may request funds to be moved from the basic health plan trust account or the basic health plan subscription account to the basic health plan self-insurance reserve account established in RCW 41.05.140.

(10) Subsections (2) and (3) of this section expire July 1, 2016.

NEW SECTION. **Sec. 5.** A new section is added to chapter 70.47 RCW to read as follows:

(1) For services provided to plan enrollees on or after the effective date of this section, nonparticipating providers must accept as payment in full the amount paid by the managed health care system under RCW 70.47.100(2) in addition to any deductible, coinsurance, or copayment that is due from the enrollee under the terms and conditions set forth in the managed health care system contract with the administrator. A plan enrollee is not liable to any nonparticipating provider for covered services, except for amounts due for any deductible, coinsurance, or copayment under the terms and conditions set forth in the managed health care system contract with the administrator.

(2) This section expires July 1, 2016.

NEW SECTION. **Sec. 6.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected."

Correct the title.

and the same are herewith transmitted.

BARBARA BAKER, Chief Clerk

MOTION

Senator Keiser moved that the Senate concur in the House amendment(s) to Engrossed Substitute Senate Bill No. 5927.

Senator Keiser spoke in favor of the motion.

Senator Becker spoke against the motion.

The President declared the question before the Senate to be the motion by Senator Keiser that the Senate concur in the House amendment(s) to Engrossed Substitute Senate Bill No. 5927.

The motion by Senator Keiser carried and the Senate concurred in the House amendment(s) to Engrossed Substitute Senate Bill No. 5927 by voice vote.

The President declared the question before the Senate to be the final passage of Engrossed Substitute Senate Bill No. 5927, as amended by the House.

ROLL CALL

The Secretary called the roll on the final passage of Engrossed Substitute Senate Bill No. 5927, as amended by the House, and the bill passed the Senate by the following vote: Yeas, 34; Nays, 11; Absent, 0; Excused, 4.

Voting yea: Senators Baxter, Brown, Carrell, Chase, Conway, Delvin, Eide, Fraser, Hargrove, Harper, Hatfield, Haugen, Hewitt, Hobbs, Kastama, Keiser, Kilmer, Kline, Kohl-Welles, McAuliffe, Morton, Murray, Nelson, Pflug, Prentice, Pridemore, Ranker, Regala, Roach, Rockefeller, Schoesler, Tom, White and Zarelli

Voting nay: Senators Baumgartner, Becker, Ericksen, Fain, Hill, Holmquist Newbry, Honeyford, King, Litzow, Parlette and Stevens

Excused: Senators Benton, Sheldon, Shin and Swecker

ENGROSSED SUBSTITUTE SENATE BILL NO. 5927, as amended by the House, having received the constitutional majority, was declared passed. There being no objection, the title of the bill was ordered to stand as the title of the act.

MOTION

On motion of Senator Eide, the Senate advanced to the sixth order of business.

SECOND READING

ENGROSSED SECOND SUBSTITUTE HOUSE BILL NO. 1795, by House Committee on Ways & Means (originally sponsored by Representatives Carlyle, Seaquist, Haler, Reykdal, Rolfes, Probst, Morris, Sells, Pedersen, Jacks, Hudgins, Maxwell and Frockt)

Enacting the higher education opportunity act.

The measure was read the second time.

MOTION

On motion of Senator Tom, the rules were suspended, Engrossed Second Substitute House Bill No. 1795 was advanced to third reading, the second reading considered the third and the bill was placed on final passage.

Senators Tom, Hill, Hargrove, Hobbs, Brown, Zarelli, Kohl-Welles and Kilmer spoke in favor of passage of the bill.

Senators Kastama, Pflug, Roach and Baumgartner spoke against passage of the bill.

The President declared the question before the Senate to be the final passage of Engrossed Second Substitute House Bill No. 1795.

ROLL CALL

The Secretary called the roll on the final passage of Engrossed Second Substitute House Bill No. 1795 and the bill passed the Senate by the following vote: Yeas, 32; Nays, 13; Absent, 0; Excused, 4.

Voting yea: Senators Brown, Chase, Conway, Delvin, Eide, Fain, Fraser, Hargrove, Harper, Hatfield, Haugen, Hewitt, Hill, Hobbs, Keiser, Kilmer, Kline, Kohl-Welles, Litzow, McAuliffe, Morton, Murray, Nelson, Parlette, Prentice, Pridemore, Ranker, Regala, Rockefeller, Tom, White and Zarelli

Voting nay: Senators Baumgartner, Baxter, Becker, Carrell, Ericksen, Holmquist Newbry, Honeyford, Kastama, King, Pflug, Roach, Schoesler and Stevens

Excused: Senators Benton, Sheldon, Shin and Swecker

ENGROSSED SECOND SUBSTITUTE HOUSE BILL NO. 1795, having received the constitutional majority, was declared passed. There being no objection, the title of the bill was ordered to stand as the title of the act.

SECOND READING

ENGROSSED SUBSTITUTE HOUSE BILL NO. 1277, by House Committee on Ways & Means (originally sponsored by Representative Cody)

Concerning oversight of licensed or certified long-term care settings for vulnerable adults.

The measure was read the second time.

MOTION

Senator Baxter moved that the following amendment by Senator Baxter be adopted:

On page 11, line 30, after "imposed" insert "and licensing fees"

On page 11, line 36, after "homes" insert ", and licensing and oversight of adult family homes"

On page 21, beginning on line 7, after "fee." strike all material through "clients." on line 15 and insert "The license fee shall be set at two hundred fifty dollars per year for each home. A two thousand dollar processing fee shall also be charged each home when it is initially licensed."

Senator Baxter spoke in favor of adoption of the amendment.

Senators Keiser and Zarelli spoke against adoption of the amendment.

The President declared the question before the Senate to be the adoption of the amendment by Senator Baxter on page 11, line 30 to Engrossed Substitute House Bill No. 1277.

The motion by Senator Baxter failed and the amendment was not adopted by voice vote.

MOTION

On motion of Senator Keiser, the rules were suspended, Engrossed Substitute House Bill No. 1277 was advanced to third reading, the second reading considered the third and the bill was placed on final passage.

Senators Keiser and Becker spoke in favor of passage of the bill.

The President declared the question before the Senate to be the final passage of Engrossed Substitute House Bill No. 1277.

ROLL CALL

The Secretary called the roll on the final passage of Engrossed Substitute House Bill No. 1277 and the bill passed the Senate by the following vote: Yeas, 33; Nays, 12; Absent, 0; Excused, 4.

Voting yea: Senators Becker, Brown, Chase, Conway, Delvin, Eide, Fraser, Hargrove, Harper, Hatfield, Haugen, Hewitt, Hobbs, Honeyford, Kastama, Keiser, Kilmer, Kline, Kohl-Welles, McAuliffe, Morton, Murray, Nelson, Pflug, Prentice, Pridemore, Ranker, Regala, Rockefeller, Schoesler, Tom, White and Zarelli

Voting nay: Senators Baumgartner, Baxter, Carrell, Ericksen, Fain, Hill, Holmquist Newbry, King, Litzow, Parlette, Roach and Stevens

Excused: Senators Benton, Sheldon, Shin and Swecker

ENGROSSED SUBSTITUTE HOUSE BILL NO. 1277, having received the constitutional majority, was declared passed. There being no objection, the title of the bill was ordered to stand as the title of the act.

SECOND READING

SENATE BILL NO. 5581, by Senators Keiser, Parlette, Hargrove, Shin, Conway and Kline

Creating a nursing home safety net assessment.

MOTION

On motion of Senator Murray, Substitute Senate Bill No. 5581 was substituted for Senate Bill No. 5581 and the substitute bill was placed on the second reading and read the second time.

MOTION

Senator Keiser moved that the following striking amendment by Senators Keiser and Parlette be adopted:

Strike everything after the enacting clause and insert the following:

"**Sec. 1.** RCW 74.46.431 and 2010 1st sp.s. c 34 s 3 are each amended to read as follows:

(1) Nursing facility medicaid payment rate allocations shall be facility-specific and shall have ((~~seven~~)) six components: Direct care, therapy care, support services, operations, property, and 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 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. Component rate allocations in operations, property, and financing allowance for essential community providers shall be based upon a minimum facility occupancy of ((~~eighty-five~~)) eighty-seven 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~~)) ninety-two 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~~)) ninety-five percent of licensed beds, regardless of how many beds are set up or in use. For all facilities, 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. Effective July 1, 2009, the direct care component rate allocation shall be rebased, ((~~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, ((~~2012~~)) 2013. Beginning July 1, ((~~2012~~)) 2013, the direct care component rate allocation shall be rebased biennially during every ((~~even-numbered~~)) odd-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~~)) 2011 is used for July 1, ((~~2012~~)) 2013, through June 30, ((~~2014~~)) 2015, and so forth.

(b) 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. Effective July 1, 2009, the therapy care component rate allocation shall be cost rebased, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, ((~~2012~~)) 2013. Beginning July 1, ((~~2012~~)) 2013, the therapy care component rate allocation shall be rebased biennially during every ((~~even-numbered~~)) odd-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~~)) 2011 is used for July 1, ((~~2012~~)) 2013, through June 30, ((~~2014~~)) 2015, 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. Effective July 1, 2009, the support services component rate allocation shall be cost rebased, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, ((~~2012~~)) 2013. Beginning July 1, ((~~2012~~)) 2013, the support services component rate allocation shall be rebased biennially during every ((~~even-numbered~~)) odd-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~~)) 2011 is used for July 1, ((~~2012~~)) 2013, through June 30, ((~~2014~~)) 2015, 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. Effective July 1, 2009, the operations component rate allocation shall be cost rebased, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, ((~~2012~~)) 2013. Beginning July 1, ((~~2012~~)) 2013, the operations care component rate allocation shall be rebased biennially during every ((~~even-numbered~~)) odd-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~~)) 2011 is used for July 1, ((~~2012~~)) 2013, through June 30, ((~~2014~~)) 2015, 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.

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

(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: 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 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.

(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.

(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. 2. RCW 74.46.435 and 2010 1st sp.s. c 34 s 5 are each amended to read as follows:

(1) 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 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 in the prior period or resident days as calculated on ((~~eighty-five~~)) eighty-seven percent facility occupancy for essential community providers, ((~~ninety~~)) ninety-two percent occupancy for small nonessential community providers, or ((~~ninety-two~~)) ninety-five percent facility occupancy for large nonessential community providers. 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) 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. 3. 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,~~)) The 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,~~)) The financing allowance ((~~shall be~~)) is determined by multiplying the net invested funds of each facility by ((~~.10~~)) .04, 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~~)) eighty-seven percent facility occupancy((~~. 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. The financing allowance factor of .085 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~~)) for essential community providers, ninety-two percent facility occupancy for small nonessential community providers, or ninety-five percent occupancy for large nonessential community providers. 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~~)) eighty-seven percent of the new licensed bed capacity for essential community providers, ninety-two percent facility occupancy for small nonessential community providers, or ninety-five percent occupancy 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~~)) department 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~~)) must 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~~)) is 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~~)) is 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~~)) has 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. 4. RCW 74.46.485 and 2010 1st sp.s. c 34 s 9 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. The department may adjust the case mix index for any of the lowest ten resource utilization group categories beginning with PA1 through PE2 to any case mix index that aids in achieving the purpose and intent of RCW 74.39A.007 and cost-efficient care; 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 semiannual rate settings following the date of minimum data set 3.0 implementation a previously established semiannual case mix adjustment established for the semiannual rate settings that will be used for 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 semiannual rate setting in which it used the previously established 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. 5. RCW 74.46.496 and 2010 1st sp.s. c 34 s 10 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 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~~)) the lowest 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 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. 6. RCW 74.46.501 and 2010 1st sp.s. c 34 s 11 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) 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 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) 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. To allow for the transition to minimum data set 3.0 and implementation of resource utilization group IV for July 1, 2011, through June 30, 2013, the department shall calculate rates using the medicaid average case mix scores effective for January 1, 2011, rates adjusted under RCW 74.46.485(1)(a), and the scores shall be increased each six months during the transition period by one-half of one percent. The July 1, 2013, direct care cost per case mix unit shall be calculated by utilizing 2011 direct care costs, patient days, and 2011 facility average case mix indexes based on the minimum data set 3.0 resource utilization group IV grouper 57. A facility's medicaid average case mix index shall be used to update a nursing facility's direct care component rate 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 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 semiannually shall be from the calendar six-month period commencing nine months prior to the effective date of the semiannual rate. For example, July 1, 2010, through December 31, 2010, direct care component rates shall utilize case mix averages from the October 1, 2009, through March 31, 2010, calendar quarters, and so forth.

Sec. 7. RCW 74.46.506 and 2010 1st sp.s. c 34 s 12 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) The department shall determine and update 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 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) 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) 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, to derive the facility's allowable direct care cost per resident day;

(c) 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(6)(b) to derive the facility's allowable direct care cost per case mix unit;

(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;

(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;

(f) Determine each facility's semiannual direct care component rate as follows:

(i) Any facility whose allowable cost per case mix unit is greater than one hundred ((~~twelve~~)) ten percent of the peer group median established under (e) of this subsection shall be assigned a cost per case mix unit equal to one hundred ((~~twelve~~)) 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 six-month period specified in RCW 74.46.501(6)(c);

(ii) Any facility whose allowable cost per case mix unit is less than or equal to one hundred ((~~twelve~~)) ten percent of the peer group median established under (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 six-month period specified in RCW 74.46.501(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 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. 8. RCW 74.46.515 and 2010 1st sp.s. c 34 s 15 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) The 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~~)) eight 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. 9. RCW 74.46.521 and 2010 1st sp.s. c 34 s 16 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) 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). Operations component rates for essential community providers shall be based upon a minimum occupancy of ((~~eighty-five~~)) eighty-seven percent of licensed beds. Operations component rates for small nonessential community providers shall be based upon a minimum occupancy of ((~~ninety~~)) ninety-two percent of licensed beds. Operations component rates for large nonessential community providers shall be based upon a minimum occupancy of ((~~ninety-two~~)) ninety-five percent of licensed beds.

(3) 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~~)) eighty-seven percent for essential community providers, ((~~ninety~~)) ninety-two percent for small nonessential community providers, or ((~~ninety-two~~)) ninety-five 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 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 for minimum occupancy; 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) 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.

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

(1) The department shall establish a skilled nursing facility safety net assessment medicaid share pass through or rate add-on to reimburse the medicaid share of the skilled nursing facility safety net assessment as a medicaid allowable cost consistent with section 15 of this act. This add-on shall not be considered an allowable cost for future year cost rebasing.

(2) As of the effective date of this section, supplemental payments to reimburse medicaid expenditures, including an amount to reimburse the medicaid share of the skilled nursing facility safety net assessment, not to exceed the annual medicare upper payment limit, must be provided for all years when the skilled nursing facility safety net assessment is levied, consistent with section 15 of this act. These supplemental payments, at a minimum, must be sufficient to reimburse the medicaid share of the assessment for those paying the assessment. The part of these supplemental payments that reimburses the medicaid share of the assessment are not subject to the reconciliation and settlement process provided in RCW 74.46.022(6).

NEW SECTION. **Sec. 11.** (1) For fiscal years 2012 and 2013 and subject to appropriation, the department of social and health services shall do a comparative analysis of the facility-based payment rates calculated on July 1, 2011, using the payment methodology defined in chapter 74.46 RCW as modified by sections 1 through 9 of this act, to the facility-based payment rates in effect June 30, 2010. If the facility-based payment rate calculated on July 1, 2011, is smaller than the facility-based payment rate on June 30, 2011, the difference shall be provided to the individual nursing facilities as an add-on payment per medicaid resident day.

(2) During the comparative analysis performed in subsection (1) of this section, if it is found that the direct care rate for any facility calculated under sections 1 through 9 of this act is greater than the direct care rate in effect on June 30, 2010, then the facility shall receive a ten percent direct care rate add-on to compensate that facility for taking on more acute clients than they have in the past.

(3) The rate add-ons provided in subsection (2) of this section are subject to the reconciliation and settlement process provided in RCW 74.46.022(6).

NEW SECTION. **Sec. 12.** PURPOSE, FINDINGS, AND INTENT. (1) It is the intent of the legislature to encourage maximization of financial resources eligible and available for medicaid services by establishing the skilled nursing facility safety net trust fund to receive skilled nursing facility safety net assessments to use in securing federal matching funds under federally prescribed programs available through the state medicaid plan.

(2) The purpose of this chapter is to provide for a safety net assessment on certain Washington skilled nursing facilities, which will be used solely to support payments to skilled nursing facilities for medicaid services.

(3) The legislature finds that:

(a) Washington skilled nursing facilities have proposed a skilled nursing facility safety net assessment to generate additional state and federal funding for the medicaid program, which will be used in part to restore recent reductions in skilled nursing facility reimbursement rates and provide for an increase in medicaid reimbursement rates; and

(b) The skilled nursing facility safety net assessment and skilled nursing facility safety net trust fund created in this chapter allows the state to generate additional federal financial participation for the medicaid program and provides for increased reimbursement to skilled nursing facilities.

(4) In adopting this chapter, it is the intent of the legislature:

(a) To impose a skilled nursing facility safety net assessment to be used solely for the purposes specified in this chapter;

(b) That funds generated by the assessment, including matching federal financial participation, shall not be used for purposes other than as specified in this chapter;

(c) That the total amount assessed not exceed the amount needed, in combination with all other available funds, to support the reimbursement rates and other payments authorized by this chapter, including payments under section 15 of this act; and

(d) To condition the assessment and use of the resulting funds on receiving federal approval for receipt of additional federal financial participation.

NEW SECTION. **Sec. 13.** DEFINITIONS. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Certain high volume medicaid nursing facilities" means the fewest number of facilities necessary with the highest number of medicaid days or total patient days annually to meet the statistical redistribution test at 42 C.F.R. Sec. 433.68(e)(2).

(2) "Continuing care retirement community" means a facility that provides a continuum of services by one operational entity or related organization providing independent living services, or boarding home or assisted living services under chapter 18.20 RCW, and skilled nursing services under chapter 18.51 RCW in a single contiguous campus. The number of licensed nursing home beds must be sixty percent or less of the total number of beds available in the entire continuing care retirement community. For purposes of this subsection "contiguous" means land adjoining or touching other property held by the same or related organization including land divided by a public road.

(3) "Deductions from revenue" means reductions from gross revenue resulting from an inability to collect payment of charges. Such reductions include bad debt, contractual adjustments, policy discounts and adjustments, and other such revenue deductions.

(4) "Department" means the department of social and health services.

(5) "Fund" means the skilled nursing facility safety net trust fund.

(6) "Hospital based" means a nursing facility that is physically part of, or contiguous to, a hospital. For purposes of this subsection "contiguous" has the same meaning as in subsection (2) of this section.

(7) "Medicare patient day" means a patient day for medicare beneficiaries on a medicare part A stay, medicare hospice stay, and a patient day for persons who have opted for managed care coverage using their medicare benefit.

(8) "Medicare upper payment limit" means the limitation established by federal regulations, 42 C.F.R. Sec. 447.272, that disallows federal matching funds when state medicaid agencies pay certain classes of nursing facilities an aggregate amount for services that would exceed the amount that would be paid for the same services furnished by that class of nursing facilities under medicare payment principles.

(9) "Net resident service revenue" means gross revenue from services to nursing facility residents less deductions from revenue. Net resident service revenue does not include other operating revenue or nonoperating revenue.

(10) "Nonexempt nursing facility" means a nursing facility that is not exempt from the skilled nursing facility safety net assessment.

(11) "Nonoperating revenue" means income from activities not relating directly to the day-to-day operations of an organization. Nonoperating revenue includes such items as gains on disposal of a facility's assets, dividends, and interest from security investments, gifts, grants, and endowments.

(12) "Nursing facility," "facility," or "skilled nursing facility" has the same meaning as "nursing home" as defined in RCW 18.51.010.

(13) "Other operating revenue" means income from nonresident care services to residents, as well as sales and activities to persons other than residents. It is derived in the course of operating the facility such as providing personal laundry service for residents or from other sources such as meals provided to persons other than residents, personal telephones, gift shops, and vending machines.

(14) "Related organization" means an entity which is under common ownership and/or control with, or has control of, or is controlled by, the contractor, as defined under chapter 74.46 RCW.

(a) "Common ownership" exists when an entity is the beneficial owner of five percent or more ownership interest in the contractor, as defined under chapter 74.46 RCW 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.

(15) "Resident day" means a calendar day of care provided to a nursing facility resident, excluding medicare patient days. Resident days include the day of admission and exclude the day of discharge. An admission and discharge on the same day count as one day of care. Resident days include nursing facility hospice days and exclude bedhold days for all residents.

NEW SECTION. **Sec. 14.** SKILLED NURSING FACILITY SAFETY NET ASSESSMENT FUND. (1) There is established in the state treasury the skilled nursing facility safety net trust fund. The purpose and use of the fund shall be to receive and disburse funds, together with accrued interest, in accordance with this chapter. Moneys in the fund, including interest earned, shall not be used or disbursed for any purposes other than those specified in this chapter. Any amounts expended from the fund that are later recouped by the department on audit or otherwise shall be returned to the fund.

(2) The skilled nursing facility safety net trust fund must be a separate and continuing fund, and no money in the fund reverts to the state general fund at any time. All assessments, interest, and penalties collected by the department under sections 15, 16, and 20 of this act shall be deposited into the fund.

(3) Any money received under sections 15, 16, and 20 of this act must be deposited in the state treasury for credit to the skilled nursing facility safety net trust fund, and must be expended, to the extent authorized by federal law, to obtain federal financial participation in the medicaid program and to maintain and enhance nursing facility rates in a manner set forth in subsection (4) of this section.

(4) Disbursements from the fund may be made only as follows:

(a) As an immediate pass-through or rate add-on to reimburse the medicaid share of the skilled nursing facility safety net assessment as a medicaid allowable cost;

(b) To make medicaid payments for nursing facility services in accordance with chapter 74.46 RCW and pursuant to this chapter;

(c) To refund erroneous or excessive payments made by skilled nursing facilities pursuant to this chapter;

(d) To administer the provisions of this chapter the department may expend an amount not to exceed one-half of one percent of the money received from the assessment, and must not exceed the amount authorized for expenditure by the legislature for administrative expenses in a fiscal year;

(e) To repay the federal government for any excess payments made to skilled nursing facilities from the fund if the assessments or payment increases set forth in this chapter are deemed out of compliance with federal statutes and regulations and all appeals have been exhausted. In such a case, the department may require skilled nursing facilities receiving excess payments to refund the payments in question to the fund. The state in turn shall return funds to the federal government in the same proportion as the original financing. If a skilled nursing facility is unable to refund payments, the state shall either develop a payment plan or deduct moneys from future medicaid payments, or both; and

(f) To increase nursing facility payments to fund covered services to medicaid beneficiaries within medicare upper limits.

(5) Any positive balance in the fund at the end of a fiscal year shall be applied to reduce the assessment amount for the subsequent fiscal year in accordance with section 16(1)(c)(i) of this act.

(6) Upon termination of the assessment, any amounts remaining in the fund shall be refunded to skilled nursing facilities, pro rata according to the amount paid by the facility, subject to limitations of federal law.

NEW SECTION. **Sec. 15.** ASSESSMENTS. (1) In accordance with the redistribution method set forth in 42 C.F.R. Sec. 433.68(e)(1) and (2), the department shall seek a waiver of the broad-based and uniform provider assessment requirements of federal law to exclude certain nursing facilities from the skilled nursing facility safety net assessment and to permit certain high volume medicaid nursing facilities or facilities with a high number of total annual resident days to pay the skilled nursing facility safety net assessment at a lesser amount per nonmedicare patient day.

(2) The skilled nursing facility safety net assessment shall, at no time, be greater than the maximum percentage of the nursing facility industry reported net patient service revenues allowed under federal law or regulation.

(3) All skilled nursing facility safety net assessments collected pursuant to this section by the department shall be transmitted to the state treasurer who shall credit all such amounts to the skilled nursing facility safety net trust fund.

NEW SECTION. **Sec. 16.** ADMINISTRATION AND COLLECTION. (1) The department, in cooperation with the office of financial management, shall develop rules for determining the amount to be assessed to individual skilled nursing facilities, notifying individual skilled nursing facilities of the assessed amount, and collecting the amounts due. Such rule making shall specifically include provision for:

(a) Payment of the skilled nursing facility safety net assessment;

(b) Interest on delinquent assessments;

(c) Adjustment of the assessment amounts as follows:

(i) The assessment amounts under section 15 of this act may be adjusted as follows:

(A) If sufficient other appropriated funds for skilled nursing facilities, are available to support the nursing facility reimbursement rates as authorized in the biennial appropriations act and other uses and payments permitted by sections 14 and 15 of this act without utilizing the full assessment authorized under section 15 of this act, the department shall reduce the amount of the assessment to the minimum level necessary to support those reimbursement rates and other uses and payments.

(B) So long as none of the conditions set forth in section 18(2) of this act have occurred, if the department's forecasts indicate that the assessment amounts under section 15 of this act, together with all other appropriated funds, are not sufficient to support the skilled nursing facility reimbursement rates authorized in the biennial appropriations act and other uses and payments authorized under sections 14 and 15 of this act, the department shall increase the assessment rates to the amount necessary to support those reimbursement rates and other payments to the maximum amount allowable under federal law.

(C) Any positive balance remaining in the fund at the end of the fiscal year shall be applied to reduce the assessment amount for the subsequent fiscal year.

(ii) Beginning July 1, 2012, any adjustment to the assessment amounts pursuant to this subsection, and the data supporting such adjustment, including but not limited to relevant data listed in subsection (2) of this section, must be submitted to the Washington health care association, and aging services of Washington, for review and comment at least sixty calendar days prior to implementation of such adjusted assessment amounts. Any review and comment provided by the Washington health care association, and aging services of Washington, shall not limit the ability of either association or its members to challenge an adjustment or other action by the department that is not made in accordance with this chapter.

(2) By November 30th of each year, the department shall provide the following data to the office of financial management, the chair of the fiscal committee of the senate and the house of representatives, the Washington health care association, and aging services of Washington:

(a) The fund balance; and

(b) The amount of assessment paid by each skilled nursing facility.

(3) Assessments shall be assessed from the effective date of this section.

NEW SECTION. **Sec. 17.** EXCEPTIONS. (1) Subject to subsection (4) of this section the department shall exempt the following nursing facility providers from the skilled nursing facility safety net assessment subject to federal approval under 42 C.F.R. Sec. 433.68(e)(2):

(a) Continuing care retirement communities;

(b) Nursing facilities with thirty-five or fewer licensed beds;

(c) State, tribal, and county operated nursing facilities; and

(d) Any nursing facility operated by a public hospital district and nursing facilities that are hospital-based.

(2) The department shall lower the skilled nursing facility safety net assessment for either certain high volume medicaid nursing facilities or certain facilities with high resident volumes to meet the redistributive tests of 42 C.F.R. Sec. 433.68(e)(2).

(3) The department shall lower the skilled nursing facility safety net assessment for any skilled nursing facility with a licensed bed capacity in excess of two hundred three beds to the same level described in subsection (2) of this section.

(4) To the extent necessary to obtain federal approval under 42 C.F.R. Sec. 433.68(e)(2), the exemptions prescribed in subsections (1), (2), and (3) of this section may be amended by the department.

(5) The per resident day assessment rate shall be the same amount for each affected facility except as prescribed in subsections (1), (2), and (3) of this section.

(6) The department shall notify the nursing facility operators of any skilled nursing facilities that would be exempted from the skilled nursing facility safety net assessment pursuant to the waiver request submitted to the United States department of health and human services under this section.

NEW SECTION. **Sec. 18.** CONDITIONS. (1) If the centers for medicare and medicaid services fail to approve any state plan amendments or waiver requests that are necessary in order to implement the applicable sections of this chapter then the assessment authorized in section 16 of this act shall cease to be imposed.

(2) Nothing in subsection (1) of this section prohibits the department from working cooperatively with the centers for medicare and medicaid services to secure approval of any needed state plan amendments or waiver requests. As provided in sections 15 and 17 of this act, the department shall adjust any submitted state plan amendments or waiver requests as necessary to achieve approval.

(3) If this chapter does not take effect or ceases to be imposed, any moneys remaining in the fund shall be refunded to skilled nursing facilities in proportion to the amounts paid by such facilities.

NEW SECTION. **Sec. 19.** ASSESSMENT PART OF OPERATING OVERHEAD. The incidence and burden of assessments imposed under this chapter shall be on skilled nursing facilities and the expense associated with the assessments shall constitute a part of the operating overhead of the facilities. Skilled nursing facilities shall not itemize the safety net assessment on billings to residents or third-party payers.

NEW SECTION. **Sec. 20.** ENFORCEMENT. If a nursing facility fails to make timely payment of the safety net assessment, the department may seek a remedy provided by law, including, but not limited to:

(1) Withholding any medical assistance reimbursement payments until such time as the assessment amount is recovered;

(2) Suspension or revocation of the nursing facility license; or

(3) Imposition of a civil fine up to one thousand dollars per day for each delinquent payment, not to exceed the amount of the assessment.

NEW SECTION. **Sec. 21.** QUALITY INCENTIVE PAYMENTS. (1) The department and the department of health, in consultation with the Washington state health care association, and aging services of Washington, shall design a system of skilled nursing facility quality incentive payments. The design of the system shall be submitted to the relevant policy and fiscal committees of the legislature by December 15, 2011. The system shall be based upon the following principles:

(a) Evidence-based treatment and processes shall be used to improve health care outcomes for skilled nursing facility residents;

(b) Effective purchasing strategies to improve the quality of health care services should involve the use of common quality improvement measures, while recognizing that some measures may not be appropriate for application to facilities with high bariatric, behaviorally challenged, or rehabilitation populations;

(c) Quality measures chosen for the system should be consistent with the standards that have been developed by national quality improvement organizations, such as the national quality forum, the federal centers for medicare and medicaid services, or the federal agency for healthcare research and quality. New reporting burdens to skilled nursing facilities should be minimized by giving priority to measures skilled nursing facilities that are currently required to report to governmental agencies, such as the nursing home compare measures collected by the federal centers for medicare and medicaid services;

(d) Benchmarks for each quality improvement measure should be set at levels that are feasible for skilled nursing facilities to achieve, yet represent real improvements in quality and performance for a majority of skilled nursing facilities in Washington state; and

(e) Skilled nursing facilities performance and incentive payments should be designed in a manner such that all facilities in Washington are able to receive the incentive payments if performance is at or above the benchmark score set in the system established under this section.

(2) Pursuant to an appropriation by the legislature, for state fiscal year 2013 and each fiscal year thereafter, assessments may be increased to support an additional one percent increase in skilled nursing facility reimbursement rates for facilities that meet the quality incentive benchmarks established under this section.

Sec. 22. RCW 43.84.092 and 2010 1st sp.s. c 30 s 20, 2010 1st sp.s. c 9 s 7, 2010 c 248 s 6, 2010 c 222 s 5, 2010 c 162 s 6, and 2010 c 145 s 11 are each reenacted and amended to read as follows:

(1) All earnings of investments of surplus balances in the state treasury shall be deposited to the treasury income account, which account is hereby established in the state treasury.

(2) The treasury income account shall be utilized to pay or receive funds associated with federal programs as required by the federal cash management improvement act of 1990. The treasury income account is subject in all respects to chapter 43.88 RCW, but no appropriation is required for refunds or allocations of interest earnings required by the cash management improvement act. Refunds of interest to the federal treasury required under the cash management improvement act fall under RCW 43.88.180 and shall not require appropriation. The office of financial management shall determine the amounts due to or from the federal government pursuant to the cash management improvement act. The office of financial management may direct transfers of funds between accounts as deemed necessary to implement the provisions of the cash management improvement act, and this subsection. Refunds or allocations shall occur prior to the distributions of earnings set forth in subsection (4) of this section.

(3) Except for the provisions of RCW 43.84.160, the treasury income account may be utilized for the payment of purchased banking services on behalf of treasury funds including, but not limited to, depository, safekeeping, and disbursement functions for the state treasury and affected state agencies. The treasury income account is subject in all respects to chapter 43.88 RCW, but no appropriation is required for payments to financial institutions. Payments shall occur prior to distribution of earnings set forth in subsection (4) of this section.

(4) Monthly, the state treasurer shall distribute the earnings credited to the treasury income account. The state treasurer shall credit the general fund with all the earnings credited to the treasury income account except:

(a) The following accounts and funds shall receive their proportionate share of earnings based upon each account's and fund's average daily balance for the period: The aeronautics account, the aircraft search and rescue account, the budget stabilization account, the capitol building construction account, the Cedar River channel construction and operation account, the Central Washington University capital projects account, the charitable, educational, penal and reformatory institutions account, the cleanup settlement account, the Columbia river basin water supply development account, the common school construction fund, the county arterial preservation account, the county criminal justice

assistance account, the county sales and use tax equalization account, the deferred compensation administrative account, the deferred compensation principal account, the department of licensing services account, the department of retirement systems expense account, the developmental disabilities community trust account, the drinking water assistance account, the drinking water assistance administrative account, the drinking water assistance repayment account, the Eastern Washington University capital projects account, the education construction fund, the education legacy trust account, the election account, the energy freedom account, the energy recovery act account, the essential rail assistance account, The Evergreen State College capital projects account, the federal forest revolving account, the ferry bond retirement fund, the freight congestion relief account, the freight mobility investment account, the freight mobility multimodal account, the grade crossing protective fund, the public health services account, the health system capacity account, the high capacity transportation account, the state higher education construction account, the higher education construction account, the highway bond retirement fund, the highway infrastructure account, the highway safety account, the high occupancy toll lanes operations account, the hospital safety net assessment fund, the industrial insurance premium refund account, the judges' retirement account, the judicial retirement administrative account, the judicial retirement principal account, the local leasehold excise tax account, the local real estate excise tax account, the local sales and use tax account, the marine resources stewardship trust account, the medical aid account, the mobile home park relocation fund, the motor vehicle fund, the motorcycle safety education account, the multiagency permitting team account, the multimodal transportation account, the municipal criminal justice assistance account, the municipal sales and use tax equalization account, the natural resources deposit account, the oyster reserve land account, the pension funding stabilization account, the perpetual surveillance and maintenance account, the public employees' retirement system plan 1 account, the public employees' retirement system combined plan 2 and plan 3 account, the public facilities construction loan revolving account beginning July 1, 2004, the public health supplemental account, the public transportation systems account, the public works assistance account, the Puget Sound capital construction account, the Puget Sound ferry operations account, the Puyallup tribal settlement account, the real estate appraiser commission account, the recreational vehicle account, the regional mobility grant program account, the resource management cost account, the rural arterial trust account, the rural Washington loan fund, the site closure account, the skilled nursing facility safety net trust fund, the small city pavement and sidewalk account, the special category C account, the special wildlife account, the state employees' insurance account, the state employees' insurance reserve account, the state investment board expense account, the state investment board commingled trust fund accounts, the state patrol highway account, the state route number 520 civil penalties account, the state route number 520 corridor account, the supplemental pension account, the Tacoma Narrows toll bridge account, the teachers' retirement system plan 1 account, the teachers' retirement system combined plan 2 and plan 3 account, the tobacco prevention and control account, the tobacco settlement account, the transportation 2003 account (nickel account), the transportation equipment fund, the transportation fund, the transportation improvement account, the transportation improvement board bond retirement account, the transportation infrastructure account, the transportation partnership account, the traumatic brain injury account, the tuition recovery trust fund, the University of Washington bond retirement fund, the University of Washington building account, the urban arterial trust account, the volunteer firefighters' and reserve officers' relief and pension principal fund, the volunteer firefighters' and reserve officers' administrative fund, the Washington judicial retirement system account, the Washington law enforcement officers' and firefighters' system plan 1 retirement account, the Washington law enforcement officers' and firefighters' system plan 2 retirement account, the Washington public safety employees' plan 2 retirement account, the Washington school employees' retirement system combined plan 2 and 3 account, the Washington state health insurance pool account, the Washington state patrol retirement account, the Washington State University building account, the Washington State University bond retirement fund, the water pollution control revolving fund, and the Western Washington University capital projects account. Earnings derived from investing balances of the agricultural permanent fund, the normal school permanent fund, the permanent common school fund, the scientific permanent fund, and the state university permanent fund shall be allocated to their respective beneficiary accounts.

(b) Any state agency that has independent authority over accounts or funds not statutorily required to be held in the state treasury that deposits funds into a fund or account in the state treasury pursuant to an agreement with the office of the state treasurer shall receive its proportionate share of earnings based upon each account's or fund's average daily balance for the period.

(5) In conformance with Article II, section 37 of the state Constitution, no treasury accounts or funds shall be allocated earnings without the specific affirmative directive of this section.

NEW SECTION. **Sec. 23.** RCW 74.46.433 (Variable return component rate allocation) and 2010 1st sp.s. c 34 s 4, 2006 c 258 s 3, 2001 1st sp.s. c 8 s 6, & 1999 c 353 s 9 are each repealed.

NEW SECTION. **Sec. 24.** Except as provided in section 18 of this act, if any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 25.** Sections 12 through 21 and 24 of this act constitute a new chapter in Title 74 RCW.

NEW SECTION. **Sec. 26.** 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, 2011."

Senators Keiser and Parlette spoke in favor of adoption of the striking amendment.

The President declared the question before the Senate to be the adoption of the striking amendment by Senators Keiser and Parlette to Substitute Senate Bill No. 5581.

The motion by Senator Keiser carried and the striking amendment was adopted by voice vote.

MOTION

There being no objection, the following title amendment was adopted:

On page 1, line 1 of the title, after "Relating to" strike the remainder of the title and insert "nursing homes; amending RCW 74.46.431, 74.46.435, 74.46.437, 74.46.485, 74.46.496, 74.46.501, 74.46.506, 74.46.515, and 74.46.521; reenacting and amending RCW 43.84.092; adding a new section to chapter 74.46 RCW; adding a new chapter to Title 74 RCW; creating a new section; repealing RCW 74.46.433; prescribing penalties; providing an effective date; and declaring an emergency."

POINT OF ORDER

Senator Holmquist Newbry: "I believe that this bill may require a super majority vote under Initiative 1053 and I have some arguments to offer."

REPLY BY THE PRESIDENT

President Owen: "Senator Holmquist Newbry, the President believes you're a little premature on your challenge. We are not on third reading yet."

MOTION

On motion of Senator Murray, the rules were suspended, Engrossed Substitute Senate Bill No. 5581 was advanced to third reading, the second reading considered the third and the bill was placed on final passage.

POINT OF ORDER

Senator Holmquist Newbry: "I believe that this bill may require a super-majority voter under Initiative 1053 and I have some arguments to offer. Thank you Mr. President. In your previous rulings, you have talked about the main distinction between taxes and fees. In order to be a fee there must be a very close nexus between those paying the fee and the purpose for which that fee is to be used. If those paying the charge are not in the group that benefits from the charge the charge would appear to be a more general tax. Under this bill, nursing homes will pay an assessment on each bed: private-pay and Medicaid. Nursing homes will receive a financial benefit but only for the Medicaid beds. Most nursing homes have a mix of private-pay and Medicaid beds and would therefore receive at least a partial financial benefit in exchange for the payment for the fee. However, if a nursing home is an entirely private-pay facility and does not qualify for exemption the facility would pay a fee on all beds but under the terms of this bill could never be a part of the group receiving a benefit. There's no other purpose for this bill or other benefit provided other than the redistribution of funds. I submit to you that this scenario would constitute a tax on a private-paid facility and therefore the bill is more accurately characterized as imposing a tax rather than a fee under Initiative 1053. This would require a super majority vote, I ask you to rule. Thank you Mr. President."

Senator Murray spoke against the point of order.

MOTION

On motion of Senator Eide, further consideration of Engrossed Substitute Senate Bill No. 5581 was deferred and the bill held its place on the third reading calendar.

MOTION

At 1:39 p.m., on motion of Senator Eide, the Senate adjourned until 10:00 a.m. Wednesday, May 11, 2011.

BRAD OWEN, President of the Senate

THOMAS HOEMANN, Secretary of the Senate

1131
Introduction & 1st Reading 1
Messages 1
1132-S2
Introduction & 1st Reading 1
Messages 1
1277-S
Second Reading 7
Third Reading Final Passage 7
1795-s2
Other Action 2
1795-S2
Introduction & 1st Reading 1
Messages 1
Second Reading 7
Third Reading Final Passage 7
2069
Introduction & 1st Reading 2
Messages 1
4405
President Signed 1
5581
Second Reading 7
5581-S
Other Action 16
Second Reading 8
5596-S2
Final Passage as amended by House 3
Messages 2
Other Action 2
5927-S
Final Passage as amended by House 6
Messages 3
Other Action 6
5955
Introduction & 1st Reading 1
PRESIDENT OF THE SENATE
Reply by the President 17
WASHINGTON STATE SENATE
Point of Order, Senator Holmquist Newbry 16, 17