

CERTIFICATION OF ENROLLMENT

SUBSTITUTE HOUSE BILL 1274

Chapter 2, Laws of 2015

64th Legislature
2015 2nd Special Session

NURSING HOME RATES--VALUE-BASED SYSTEM

EFFECTIVE DATE: 7/1/2015

Passed by the House June 24, 2015
Yeas 95 Nays 2

FRANK CHOPP

Speaker of the House of Representatives

Passed by the Senate June 26, 2015
Yeas 44 Nays 0

BRAD OWEN

President of the Senate

Approved June 30, 2015 3:53 PM

JAY INSLEE

Governor of the State of Washington

CERTIFICATE

I, Barbara Baker, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **SUBSTITUTE HOUSE BILL 1274** as passed by House of Representatives and the Senate on the dates hereon set forth.

BARBARA BAKER

Chief Clerk

FILED

June 30, 2015

**Secretary of State
State of Washington**

SUBSTITUTE HOUSE BILL 1274

Passed Legislature - 2015 2nd Special Session

State of Washington 64th Legislature 2015 2nd Special Session

By House Appropriations (originally sponsored by Representatives
Cody, Jenkins, Johnson, Harris, and Tharinger)

READ FIRST TIME 06/24/15.

1 AN ACT Relating to implementing a value-based system for nursing
2 home rates; amending RCW 74.46.431, 74.46.501, and 74.42.360; adding
3 new sections to chapter 74.46 RCW; creating a new section; repealing
4 RCW 74.46.431, 74.46.435, 74.46.506, 74.46.508, 74.46.511, 74.46.515,
5 and 74.46.521; providing effective dates; providing an expiration
6 date; and declaring an emergency.

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

8 **Sec. 1.** RCW 74.46.431 and 2013 2nd sp.s. c 3 s 1 are each
9 amended to read as follows:

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

16 (2) Component rate allocations in therapy care and support
17 services for all facilities shall be based upon a minimum facility
18 occupancy of eighty-five percent of licensed beds, regardless of how
19 many beds are set up or in use. Component rate allocations in
20 operations, property, and financing allowance for essential community
21 providers shall be based upon a minimum facility occupancy of eighty-

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

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

32 (4)(a) Direct care component rate allocations shall be
33 established using adjusted cost report data covering at least six
34 months. Effective July 1, 2009, the direct care component rate
35 allocation shall be rebased, so that adjusted cost report data for
36 calendar year 2007 is used for July 1, 2009, through June 30,
37 ((2015)) 2017. Beginning July 1, ((2015)) 2017, the direct care
38 component rate allocation shall be rebased biennially during every
39 odd-numbered year thereafter using adjusted cost report data from two
40 years prior to the rebase period, so adjusted cost report data for

1 calendar year ((2013)) 2015 is used for July 1, ((2015)) 2017,
2 through June 30, ((2017)) 2019, and so forth.

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

17 (5)(a) Therapy care component rate allocations shall be
18 established using adjusted cost report data covering at least six
19 months. Effective July 1, 2009, the therapy care component rate
20 allocation shall be cost rebased, so that adjusted cost report data
21 for calendar year 2007 is used for July 1, 2009, through June 30,
22 ((2015)) 2017. Beginning July 1, ((2015)) 2017, the therapy care
23 component rate allocation shall be rebased biennially during every
24 odd-numbered year thereafter using adjusted cost report data from two
25 years prior to the rebase period, so adjusted cost report data for
26 calendar year ((2013)) 2015 is used for July 1, ((2015)) 2017,
27 through June 30, ((2017)) 2019, and so forth.

28 (b) Therapy care component rate allocations established in
29 accordance with this chapter shall be adjusted annually for economic
30 trends and conditions by a factor or factors defined in the biennial
31 appropriations act. The economic trends and conditions factor or
32 factors defined in the biennial appropriations act shall not be
33 compounded with the economic trends and conditions factor or factors
34 defined in any other biennial appropriations acts before applying it
35 to the therapy care component rate allocation established in
36 accordance with this chapter. When no economic trends and conditions
37 factor or factors for either fiscal year are defined in a biennial
38 appropriations act, no economic trends and conditions factor or
39 factors defined in any earlier biennial appropriations act shall be

1 applied solely or compounded to the therapy care component rate
2 allocation established in accordance with this chapter.

3 (6)(a) Support services component rate allocations shall be
4 established using adjusted cost report data covering at least six
5 months. Effective July 1, 2009, the support services component rate
6 allocation shall be cost rebased, so that adjusted cost report data
7 for calendar year 2007 is used for July 1, 2009, through June 30,
8 ~~((2015))~~ 2017. Beginning July 1, ~~((2015))~~ 2017, the support services
9 component rate allocation shall be rebased biennially during every
10 odd-numbered year thereafter using adjusted cost report data from two
11 years prior to the rebase period, so adjusted cost report data for
12 calendar year ~~((2013))~~ 2015 is used for July 1, ~~((2015))~~ 2017,
13 through June 30, ~~((2017))~~ 2019, and so forth.

14 (b) Support services component rate allocations established in
15 accordance with this chapter shall be adjusted annually for economic
16 trends and conditions by a factor or factors defined in the biennial
17 appropriations act. The economic trends and conditions factor or
18 factors defined in the biennial appropriations act shall not be
19 compounded with the economic trends and conditions factor or factors
20 defined in any other biennial appropriations acts before applying it
21 to the support services component rate allocation established in
22 accordance with this chapter. When no economic trends and conditions
23 factor or factors for either fiscal year are defined in a biennial
24 appropriations act, no economic trends and conditions factor or
25 factors defined in any earlier biennial appropriations act shall be
26 applied solely or compounded to the support services component rate
27 allocation established in accordance with this chapter.

28 (7)(a) Operations component rate allocations shall be established
29 using adjusted cost report data covering at least six months.
30 Effective July 1, 2009, the operations component rate allocation
31 shall be cost rebased, so that adjusted cost report data for calendar
32 year 2007 is used for July 1, 2009, through June 30, ~~((2015))~~ 2017.
33 Beginning July 1, ~~((2015))~~ 2017, the operations care component rate
34 allocation shall be rebased biennially during every odd-numbered year
35 thereafter using adjusted cost report data from two years prior to
36 the rebase period, so adjusted cost report data for calendar year
37 ~~((2013))~~ 2015 is used for July 1, ~~((2015))~~ 2017, through June 30,
38 ~~((2017))~~ 2019, and so forth.

39 (b) Operations component rate allocations established in
40 accordance with this chapter shall be adjusted annually for economic

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

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

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

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

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

38 (12) Facilities obtaining a certificate of need or a certificate
39 of need exemption under chapter 70.38 RCW after June 30, 2001, must
40 have a certificate of capital authorization in order for (a) the

1 depreciation resulting from the capitalized addition to be included
2 in calculation of the facility's property component rate allocation;
3 and (b) the net invested funds associated with the capitalized
4 addition to be included in calculation of the facility's financing
5 allowance rate allocation.

6 **Sec. 2.** RCW 74.46.501 and 2013 2nd sp.s. c 3 s 2 are each
7 amended to read as follows:

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

13 (2)(a) In calculating a facility's two average case mix indexes
14 for each quarter, the department shall include all residents or
15 medicaid residents, as applicable, who were physically in the
16 facility during the quarter in question based on the resident
17 assessment instrument completed by the facility and the requirements
18 and limitations for the instrument's completion and transmission
19 (January 1st through March 31st, April 1st through June 30th, July
20 1st through September 30th, or October 1st through December 31st).

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

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

30 (4) In determining the number of days a resident is classified
31 into a particular case mix group, the department shall determine a
32 start date for calculating case mix grouping periods as specified by
33 rule.

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

1 (6)(a) Although the facility average and the medicaid average
2 case mix indexes shall both be calculated quarterly, the cost-
3 rebasing period facility average case mix index will be used
4 throughout the applicable cost-rebasing period in combination with
5 cost report data as specified by RCW 74.46.431 and 74.46.506, to
6 establish a facility's allowable cost per case mix unit. To allow for
7 the transition to minimum data set 3.0 and implementation of resource
8 utilization group IV for July 1, ((2013)) 2015, through June 30,
9 ((2015)) 2017, the department shall calculate rates using the
10 medicaid average case mix scores effective for January 1, ((2013))
11 2015, rates adjusted under RCW 74.46.485(1)(a), and the scores shall
12 be increased each six months during the transition period by one-half
13 of one percent. The July 1, ((2015)) 2017, direct care cost per case
14 mix unit shall be calculated by utilizing ((2013)) 2015 direct care
15 costs, patient days, and ((2013)) 2015 facility average case mix
16 indexes based on the minimum data set 3.0 resource utilization group
17 IV grouper 57. Otherwise, a facility's medicaid average case mix
18 index shall be used to update a nursing facility's direct care
19 component rate semiannually.

20 (b) The facility average case mix index used to establish each
21 nursing facility's direct care component rate shall be based on an
22 average of calendar quarters of the facility's average case mix
23 indexes from the four calendar quarters occurring during the cost
24 report period used to rebase the direct care component rate
25 allocations as specified in RCW 74.46.431.

26 (c) The medicaid average case mix index used to update or
27 recalibrate a nursing facility's direct care component rate
28 semiannually shall be from the calendar six-month period commencing
29 nine months prior to the effective date of the semiannual rate. For
30 example, July 1, 2010, through December 31, 2010, direct care
31 component rates shall utilize case mix averages from the October 1,
32 2009, through March 31, 2010, calendar quarters, and so forth.

33 NEW SECTION. **Sec. 3.** A new section is added to chapter 74.46
34 RCW to read as follows:

35 (1) For fiscal year 2016 and subject to appropriation, the
36 department shall do a comparative analysis of the facility-based
37 payment rates calculated on July 1, 2015, using the payment
38 methodology defined in this chapter, to the facility-based rates in
39 effect June 30, 2010. If the facility-based payment rate calculated

1 on July 1, 2015, is smaller than the facility-based payment rate on
2 June 30, 2010, the difference must be provided to the individual
3 nursing facilities as an add-on per medicaid resident day.

4 (2) During the comparative analysis performed in subsection (1)
5 of this section, for fiscal year 2016, if it is found that the direct
6 care rate for any facility calculated under this chapter is greater
7 than the direct care rate in effect on June 30, 2010, then the
8 facility must receive a ten percent direct care rate add-on to
9 compensate that facility for taking on more acute clients than it has
10 in the past.

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

14 NEW SECTION. **Sec. 4.** A new section is added to chapter 74.46
15 RCW to read as follows:

16 (1) The legislature adopts a new system for establishing nursing
17 home payment rates beginning July 1, 2016. Any payments to nursing
18 homes for services provided after June 30, 2016, must be based on the
19 new system. The new system must be designed in such a manner as to
20 decrease administrative complexity associated with the payment
21 methodology, reward nursing homes providing care for high acuity
22 residents, incentivize quality care for residents of nursing homes,
23 and establish minimum staffing standards for direct care.

24 (2) The new system must be based primarily on industry-wide
25 costs, and have three main components: Direct care, indirect care,
26 and capital.

27 (3) The direct care component must include the direct care and
28 therapy care components of the previous system, along with food,
29 laundry, and dietary services. Direct care must be paid at a fixed
30 rate, based on one hundred percent of facility-wide case mix neutral
31 median costs. Direct care must be performance-adjusted for acuity
32 every six months, using case mix principles. Direct care must be
33 regionally adjusted for nonmetropolitan and metropolitan statistical
34 areas. There is no minimum occupancy for direct care.

35 (4) The indirect care component must include the elements of
36 administrative expenses, maintenance costs, and housekeeping services
37 from the previous system. A minimum occupancy assumption of ninety
38 percent must be applied to indirect care. Indirect care must be paid
39 at a fixed rate, based on ninety percent of facility-wide median

1 costs. Indirect care must be regionally adjusted for nonmetropolitan
2 and metropolitan statistical areas.

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

7 (6) A quality incentive must be offered as a rate enhancement
8 beginning July 1, 2016. An enhancement no larger than five percent of
9 the statewide average daily rate must be paid to facilities that meet
10 or exceed the standard established for the quality incentive. All
11 providers must have the opportunity to earn the full quality
12 incentive. The department must recommend four to six measures to
13 become the standard for the quality incentive, and must describe a
14 system for rewarding incremental improvement related to these four to
15 six measures, within the report to the legislature described in
16 section 6 of this act. Infection rates, pressure ulcers, staffing
17 turnover, fall prevention, utilization of antipsychotic medication,
18 and hospital readmission rates are examples of measures that may be
19 established for the quality incentive.

20 (7) Reimbursement of the safety net assessment imposed by chapter
21 74.48 RCW and paid in relation to medicaid residents must be
22 continued.

23 (8) The direct care and indirect care components must be rebased
24 in even-numbered years, beginning with rates paid on July 1, 2016.
25 Rates paid on July 1, 2016, must be based on the 2014 calendar year
26 cost report. On a percentage basis, after rebasing, the department
27 must confirm that the statewide average daily rate has increased at
28 least as much as the average rate of inflation, as determined by the
29 skilled nursing facility market basket index published by the centers
30 for medicare and medicaid services, or a comparable index. If after
31 rebasing, the percentage increase to the statewide average daily rate
32 is less than the average rate of inflation for the same time period,
33 the department is authorized to increase rates by the difference
34 between the percentage increase after rebasing and the average rate
35 of inflation.

36 (9) The direct care component provided in subsection (3) of this
37 section is subject to the reconciliation and settlement process
38 provided in RCW 74.46.022(6). Beginning July 1, 2016, pursuant to
39 rules established by the department, funds that are received through
40 the reconciliation and settlement process provided in RCW

1 74.46.022(6) must be used for technical assistance, specialized
2 training, or an increase to the quality enhancement established in
3 subsection (6) of this section. The legislature intends to review the
4 utility of maintaining the reconciliation and settlement process
5 under a price-based payment methodology, and may discontinue the
6 reconciliation and settlement process after the 2017-2019 fiscal
7 biennium.

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

15 NEW SECTION. **Sec. 5.** A new section is added to chapter 74.46
16 RCW to read as follows:

17 The department shall adopt rules as are necessary and reasonable
18 to effectuate and maintain the new system for establishing nursing
19 home payment rates described in section 4 of this act and the minimum
20 staffing standards described in RCW 74.42.360. The rules must be
21 consistent with the principles described in section 4 of this act and
22 RCW 74.42.360. In adopting such rules, the department shall solicit
23 the opinions of nursing facility providers, nursing facility provider
24 associations, nursing facility employees, and nursing facility
25 consumer groups.

26 NEW SECTION. **Sec. 6.** (1) The department of social and health
27 services shall facilitate a work group process to propose
28 modifications to the price-based nursing facility payment methodology
29 outlined in section 4 of this act and the minimum staffing standards
30 outlined in RCW 74.42.360. The department shall keep a public record
31 of comments submitted by stakeholders throughout the work group
32 process. The work group shall consist of nursing facility provider
33 associations, a representative from a not-for-profit hospital system
34 that operates three or more nursing facilities and is not a member of
35 either statewide nursing facility provider association, nursing
36 facility employees, consumer groups, worker representatives, and the
37 office of financial management. The department shall make its final
38 recommendations to the appropriate legislative committees by January

1 2, 2016, and shall include a dissent report if agreement is not
2 achieved among stakeholders and the department. The department shall
3 include at least one meeting dedicated to review and analysis of
4 other states with price-based methodologies and must include
5 information on how well each state is achieving quality care outcomes
6 and any specific quality metrics targeted for enhanced payments in
7 comparison to the price-based rates paid to that state's nursing
8 facilities.

9 (2) This section expires August 1, 2016.

10 **Sec. 7.** RCW 74.42.360 and 1979 ex.s. c 211 s 36 are each amended
11 to read as follows:

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

16 (2) The department shall institute minimum staffing standards for
17 nursing homes. Beginning July 1, 2016, facilities must provide a
18 minimum of 3.4 hours per resident day of direct care. Direct care
19 includes registered nurses, licensed practical nurses, and certified
20 nursing assistants. The minimum staffing standard includes the time
21 when such staff are providing hands-on care related to activities of
22 daily living and nursing-related tasks, as well as care planning. The
23 legislature intends to increase the minimum staffing standard to 4.1
24 hours per resident day of direct care, but the effective date of a
25 standard higher than 3.4 hours per resident day of direct care will
26 be identified if and only if funding is provided explicitly for an
27 increase of the minimum staffing standard for direct care.

28 (a) The department shall establish in rule a system of compliance
29 of minimum direct care staffing standards by January 1, 2016.
30 Oversight must be done at least quarterly using nursing home facility
31 census and payroll data.

32 (b) The department shall establish in rule by January 1, 2016, a
33 system of financial penalties for facilities out of compliance with
34 minimum staffing standards. Beginning July 1, 2016, pursuant to rules
35 established by the department, funds that are received from financial
36 penalties must be used for technical assistance, specialized
37 training, or an increase to the quality enhancement established in
38 section 4 of this act.

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

4 (4) Essential community providers and small nonessential
5 community providers must have a registered nurse on duty directly
6 supervising resident care a minimum of sixteen hours per day, seven
7 days per week, and a registered nurse or a licensed practical nurse
8 on duty directly supervising resident care the remaining eight hours
9 per day, seven days per week.

10 NEW SECTION. Sec. 8. A new section is added to chapter 74.46
11 RCW to read as follows:

12 A separate nursing facility quality enhancement account is
13 created in the custody of the state treasurer. Beginning July 1,
14 2015, all receipts from the reconciliation and settlement process
15 provided in RCW 74.46.022(6), as described within section 4 of this
16 act, must be deposited into the account. Beginning July 1, 2016, all
17 receipts from the system of financial penalties for facilities out of
18 compliance with minimum staffing standards, as described within RCW
19 74.42.360, must be deposited into the account. Only the secretary, or
20 the secretary's designee, may authorize expenditures from the
21 account. The account is subject to allotment procedures under chapter
22 43.88 RCW, but an appropriation is not required for expenditures. The
23 department shall use the special account only for technical
24 assistance for nursing facilities, specialized training for nursing
25 facilities, or an increase to the quality enhancement established in
26 section 4 of this act.

27 NEW SECTION. Sec. 9. The following acts or parts of acts, as
28 now existing or hereafter amended are each repealed, effective June
29 30, 2016:

30 (1) RCW 74.46.431 (Nursing facility medicaid payment rate
31 allocations—Components—Minimum wage—Rules) and 2015 1st sp.s.
32 c . . . s 1 (section 1 of this act), 2013 2nd sp.s. c 3 s 1, 2011 1st
33 sp.s. c 7 s 1, 2010 1st sp.s. c 34 s 3, 2009 c 570 s 1, 2008 c 263 s
34 2, 2007 c 508 s 2, 2006 c 258 s 2, 2005 c 518 s 944, 2004 c 276 s
35 913, 2001 1st sp.s. c 8 s 5, 1999 c 353 s 4, & 1998 c 322 s 19;

36 (2) RCW 74.46.435 (Property component rate allocation) and 2011
37 1st sp.s. c 7 s 2, 2010 1st sp.s. c 34 s 5, 2001 1st sp.s. c 8 s 7,
38 1999 c 353 s 10, & 1998 c 322 s 29;

1 (3) RCW 74.46.506 (Direct care component rate allocations—
2 Determination—Quarterly updates—Fines) and 2011 1st sp.s. c 7 s 7,
3 2010 1st sp.s. c 34 s 12, 2007 c 508 s 3, 2006 c 258 s 6, & 2001 1st
4 sp.s. c 8 s 10;

5 (4) RCW 74.46.508 (Direct care component rate allocation—
6 Increases—Rules) and 2010 1st sp.s. c 34 s 13, 2003 1st sp.s. c 6 s
7 1, & 1999 c 181 s 2;

8 (5) RCW 74.46.511 (Therapy care component rate allocation—
9 Determination) and 2010 1st sp.s. c 34 s 14, 2008 c 263 s 3, 2007 c
10 508 s 4, & 2001 1st sp.s. c 8 s 11;

11 (6) RCW 74.46.515 (Support services component rate allocation—
12 Determination—Emergency situations) and 2011 1st sp.s. c 7 s 8, 2010
13 1st sp.s. c 34 s 15, 2008 c 263 s 4, 2001 1st sp.s. c 8 s 12, 1999 c
14 353 s 7, & 1998 c 322 s 27; and

15 (7) RCW 74.46.521 (Operations component rate allocation—
16 Determination) and 2011 1st sp.s. c 7 s 9, 2010 1st sp.s. c 34 s 16,
17 2007 c 508 s 5, 2006 c 258 s 7, 2001 1st sp.s. c 8 s 13, 1999 c 353 s
18 8, & 1998 c 322 s 28.

19 NEW SECTION. **Sec. 10.** This act is necessary for the immediate
20 preservation of the public peace, health, or safety, or support of
21 the state government and its existing public institutions, and takes
22 effect July 1, 2015.

Passed by the House June 24, 2015.
Passed by the Senate June 26, 2015.
Approved by the Governor June 30, 2015.
Filed in Office of Secretary of State June 30, 2015.

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